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Violence and aggression management training for trainers and managers

A national evaluation of the training provision in healthcare settings

Prepared by the **University of Nottingham**
for the Health and Safety Executive 2006

RESEARCH REPORT 440

Violence and aggression management training for trainers and managers

A national evaluation of the training provision in healthcare settings

Part 1: Research Report

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The delivery of workplace violence management training constitutes a central part of the Healthcare sectors strategy for combating work-related violence and aggression. Given the priority which is thereby accorded to violence management training, there is an urgent need to carry out a rigorous and systematic evaluation of its impact and effectiveness. Without such an evaluation Healthcare organisations will have little, if any, reliable and valid evidence as to the effects and value of the training they invest in. In addition to its ability to contribute towards an organisation's legal requirement to monitor and evaluate the effectiveness of any actions taken to prevent exposure to violence at work, evidence that is gathered from training evaluations is also fundamental to improving the content and delivery of such training. The training evaluation research that is herewith described set out both to directly assess the usefulness of violence management training and, on the basis of such evidence, to offer, in the opinion of the authors, clear guidance on good practice in the content and delivery of such training. A complementary practitioner report containing tools and guidance for violence management training is provided in Part 2.

This report and the work it describes were funded by the Health and Safety Executive (HSE). Its contents, including any opinions and/or conclusions expressed, are those of the authors alone and do not necessarily reflect HSE policy.

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First published 2006

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ACKNOWLEDGEMENTS

We would like to thank the Health and Safety Executive for funding this research. Particular thanks go to Josephine Gravell for her continued support and guidance throughout the project. We are also very grateful to John Grant and Judith Reilly for their help throughout the research process. We also extend our thanks to all members of the Steering Group and thank them for their input and guidance throughout this research.

We also extend our gratitude to all the individuals who assisted and collaborated with us during the earlier and qualitative stages of the research.

We are extremely grateful to all those participating organisations that have helped us in our research and extend this thanks to all the individuals who completed the questionnaires.

We finally would like to thank Angeli Santos for all her help and support and Marissa Gousti for all her input.

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EXECUTIVE SUMMARY

Work-related violence is now considered by many as one of the most serious occupational hazards facing staff working in the Healthcare sector. With the growing evidence of the scale of the problem and the damage it causes, a number of strategic responses at both a local and national level have been launched to meet this challenge. What is clear from the positive action that is underway across the Healthcare sector is that there is no single solution to preventing workplace violence and aggression. Interventions to prevent and manage work-related violence must be considered within the broader context and framework of a total organisational response. What is also clear is that training is often held to be a primary element of the strategy for combating work-related violence. However, with the huge investment accorded to training in this area within the Healthcare sector the question is no longer "should we train?" but "is training worthwhile and effective?"

The report by the NAO (2003) concluded that although there was lots of evidence of training in violence management being offered to staff within Healthcare there was little evidence based information regarding its effectiveness. Evaluation of the effectiveness of training programmes is critical because, without it, organizations have no good way to know whether training budgets are being spent wisely. In addition, it is important for any organisation to recognise whether the intervention prescribed (i.e. training in violence management) is suitable for the problem that has been diagnosed. This is also supported by the more recent Wales Audit Office (WAO) report which concluded that 'it is essential that Trusts evaluate the quality and impact of the training they provide and take remedial action to improve the delivery of training' (2005, pp. 39).

On the evidence base available prior to the research documented in this report, the simple answer to the question 'is training effective?' was, by and large, 'we don't know'! On the basis of the substantial data gathered during the project we are now in much stronger position to assess the impact of violence management training. In addition, important lessons have been learned and can now be disseminated about how to evaluate violence management training. Furthermore, and arguably for the first time, we also have hard evidence to inform the broad contours of an effective curricula.

This report details the key research findings in answer to two fundamental questions 1) what impact does violence management training have? and 2) what's the broad content and curriculum of the most effective violence management training? A companion practitioner report specifically addresses the issues of how to evaluate training and in doing so offers a series of tools to support and guide those with a responsibility or interest in designing, delivering or managing violence management training.

Why evaluate is, however, only one of the key questions that must be answered. The second equally crucial question is ***'what should training evaluations evaluate'?*** Although the case can be made to evaluate training on a variety of criteria, a key measure of the success or effectiveness of any programme of instruction is the realisation within a delegate that training has provided them with a healthy sense of belief in their capability to perform and to cope with the work situations that they might face.

To date there is a relative paucity of well-designed evaluation studies into the effectiveness of the training to prevent and manage violence in Healthcare settings. Using a before, after and follow-up

design, training programmes in violence management within Healthcare settings were evaluated. The key criterion against which training was evaluated was on the concept of capability. However the impact of training on other important variables (i.e. anxiety, fear of violence, etc.) was also determined.

To this end the objectives of the research were as follows:

1. To examine a broader range of outcomes against which the effectiveness of violence management training can be assessed.

2. To produce an evidence-based evaluation of the effectiveness of current violence management training programmes.

3. To establish how violence management training 'works' (i.e. the content of training) in terms of its impact on the broader range of criteria.

In addition, the scope of the research was to:

4. To develop a general suite of tools and instructions for their use, covering:

    a. Assessment of training needs and the extent to which available training meets them;
    b. The evaluation of training; and
    c. An analysis of current provision against best-practice standards.

5. To develop a best-practice monitoring tool to inform those with a responsibility for assessing violence management training programmes by way of conducting a gap analysis of the training provision.

6. To provide a set of instructional case studies in the 'best practice' management of violence and aggression.

(Objectives 4, 5 & 6 are documented in the companion practitioner report).

The overall aim of the main research report, the practitioner report and the case studies is to inform and support the need for improved quality and standards and to act as a conduit for fostering greater communication and collaboration between those organisations with responsibilities for managing violence and aggression issues across the Healthcare sector.

The main findings of the research were as follows:

- In general, training in violence management across Healthcare organisations is having positive, but limited, short term benefits. What is clear from the research is that where training does not reflect a sound understanding of need, the impact of training is at best negligible and at worst negative (i.e. staff are leaving training feeling less capable in dealing with violence and aggression in the workplace).

- Training tends to have the greatest degree of impact (i.e. change) and value (i.e. contributing to the protective sense of health and well-being) when the knowledge and skill topics emphasised within the overall programme are situated within the broader context of an organisation's performance management in terms of its systems and procedures to prevent and manage violence and aggression.

- There is a fundamental and integral role for the concept of capability in both research and practice aimed at better understanding, managing and preventing workplace violence and aggression. The term capability refers to staff member's perceived ability, confidence and self-assurance that they have the necessary knowledge, skills and understanding to be able to deal and cope with the conflict situations that they might face in the work environment. This research has served to demonstrate the importance of capability by documenting 1) the critical role perceived capability in dealing with violence and aggression plays in influencing individual and organisational well-being and 2) its power and appropriateness as a benchmark criterion against which to judge the impact and effectiveness of violence management training.

With respect to strategic action the key messages from this research are as follows:

Training needs analysis, design and delivery

- There is now a need for a common benchmark (i.e. criteria) against which the value and impact of all violence and aggression training can be judged irrespective of its focus, content, or delivery method. One common benchmark is that of capability.

- What we do know about 'effective' training in violence management is that:

    a. The content tends to be broader rather than focusing on individual competence;
    b. The content tends to be more closely allied to perceived need; and
    c. The content needs to clearly demonstrate (i.e. include evidence) of a proactive organisational response to workplace violence.

Training evaluation

- The criteria against which training is to be evaluated needs to be broader, more meaningful and add value in terms of indicating the impact of training on both individual and organisational health. There needs to be a move away from a reliance on simple end of course reaction sheets. All training courses on violence management must be evaluated in terms of their impact on common benchmark criteria of which capability is one.

- It is never enough to assume that any course 'meets the bill'. Accreditation of training programmes provides a sound benchmark against which training can be reviewed, however this does and should not exclude any training programmes from rigorous, systematic and independent evaluations. An assessment of practical value, degree of learning and transfer has to be the final arbiter of training effectiveness and not accreditation in purely educational terms.

- The underpinning rationale behind all aspects of training, training evaluation and indeed other aspects of the management of violence must be to do with continuous individual and organisational learning and development and not a 'tick-the-box' enforcement / compliance

agenda. Workplace violence, like all psychosocial hazards at work, can be most effectively managed within a proactive and problem-solving approach where the process of developing a safe work environment is continuous. This proactive approach to the management of workplace violence is reflected in the legislative framework governing health and safety at work (see below):

Health and safety legislation places many important responsibilities on employers to protect their staff and others using their premises. Under the Health and Safety at Work Act 1974, employers have a legal duty to ensure, so far as is reasonably practicable, the health, safety and welfare at work of their employees. The Management of Health and Safety at Work Regulations 1999 also require employers to consider the risks to employees, including protecting employees from exposure to reasonably foreseeable violence. Employers must:

- **Establish the significance of the risk of violence and aggression;**
- **Identify what can be done to prevent or control the risk; and**
- **Produce a clear management plan to achieve this.**

Interventions for violence and aggression

- Training cannot and must not be seen as a standalone solution to violence. The measures taken to control violence and aggression must be considered within the wider context of an integrated organisational response.

- The business case for training in violence management needs to be made more robustly. Identifying and measuring the effects of training against a broad range of evaluation criteria is a necessary starting point for this. Only when we know the full impact of training can we begin to judge its full economic and organisational value. Evidence must be gathered with respect to the need for particular categories of training (i.e. specialist and non specialist) and this must be considered alongside other strategies for intervention.

Research and practice in general

- As the NAO (2003) report testifies there is frequently a gap between what trainers deliver and what trainees want in terms of their own identified needs. This points to a deeper split between research and practice in the domain of workplace violence and aggression. The application of a problem solving framework must underpin all efforts to manage work-related violence. Within this framework problem identification must precede intervention activity. Applied to training this is to say that needs must be fully and rigorously assessed as a prerequisite for effective training design and delivery.

- In order to address this gap between research and practice there is a real need for coordinated and integrated action at the national level. Without a joint-strategic agenda which unites researchers and practitioners, thinking and problem solving becomes so devolved and dissolved that communication and learning about, for example, common issues, best practice, quality research achievements becomes difficult to realise. This process of co-ordination and integrated action can be supported by, for example:

- The development and implementation of national tools to support the design, delivery and evaluation of violence management training. Taking this suggestion forward, the implementation of a national approach to the evaluation of training would, for example, support the benchmarking of training programmes (i.e. through the use of shared criteria against which to assess training) and foster greater communication of best practice between and within organisations.

- Considering more effective ways of communicating and disseminating accrued research knowledge in this area. The communication of research and practice that is user focussed is vital in supporting the development and enablement of all stakeholders within and between Healthcare organisations.

- The development of a common vehicle to manage this continuous thirst for knowledge and practitioner based tools. A vehicle which can support and co-ordinate meeting the need in a strategic manner centred around ongoing and iterative developments founded on a shared agenda.

1. INTRODUCTION

1.1 SCALE AND CONSEQUENCES OF THE PROBLEM

Work-related violence is now considered by many as one of the most serious occupational hazards facing staff working in the Healthcare sector[1]. Analysis of the 1999 and 2003 British Crime Surveys (BCS) showed nurses and other health professionals to be second only to the police and security staff in terms of their likelihood of experiencing violence at work[2,]. Although a significant drop was reported in the BCS 2005[3] report the risk of violence to those who work in Healthcare is still high. Indeed the alarming risk of violence and aggression that Healthcare professionals face is clearly demonstrated in the 2003 NAO report[4], some key findings of which are summarised below (*see Box 1*).

The risk of violence aggression across the Healthcare profession

- **Violence and aggression accounted for 40% of the health and safety incidents in the NHS reported to the NAO**
- **2000-2001 Department of Health national survey revealing 84,214 reported incidents of violence, an increase of 30% over 1998-1999**
- **NAO 2001-2002 survey showing a further 13% increase to 95,501 reported incidents and significant variation across regions of the country**
- **"The average number of incidents for mental health and learning disability Trusts is almost two and a half times the average for all trusts, despite evidence that the staff there are less likely to report incidents of verbal abuse"**
- **Estimated level of under-reporting at around 39%**

Taken from Beech and Leather[5]

Box 1

Given the high incidence statistics, the social and economic costs of workplace violence are not surprisingly substantial. The NAO report (NAO 2003:4) offered a "crude estimate" that the direct cost of violence to the NHS "is likely to be at least £69 million per annum". As Beech and Leather[5] point out, this total takes no account of staff replacement costs, treatment costs and compensation claims. Internationally, the increase in workplace violence has also been associated with crises in recruitment and retention of nursing staff [6,7].

The damage done by workplace violence is not limited to the physical injury – and even death – that can result from a physical assault. All forms of workplace violence have a profound negative impact upon psychological well-being. Indeed, a growing body of evidence links verbal abuse, threat, and even fear of violence, with impaired health and well-being e.g. increased symptoms of feeling worn out and uptight, higher levels of burnout and withdrawal, lower job satisfaction, lower commitment to the organisation and greater intention to leave the job[8]. Increased exposure to violence and aggression has also been linked to a number of negative health behaviours e.g. increased alcohol and cigarette consumption and impaired sleep patterns[9].

The negative impact of all forms of work-related violence

- **stress reactions**
- **poorer general health**
- **anxiety**
- **depression**
- **psychosomatic symptoms**
- **isolation**
- **loneliness**
- **deterioration of relationships**
- **concentration problems**
- **impaired problem-solving capacity**
- **reduced self-confidence**
- **diminished work satisfaction**
- **fear reactions**
- **post-traumatic stress**

Source Di Martino, Hoel & Cooper (2003)[10]

Box 2

Precisely because all forms of violence are now known to be severely damaging to health and well-being so there is now common acceptance of the need to define workplace violence in broad and all inclusive terms:

Incidents where the person is abused, threatened or assaulted in circumstances relating to their work, involving an explicit or implicit challenge to their safety, well-being or health. European Commission DG-V

Adopting a broad definition of work-related violence is fundamental to the likely success of any initiatives designed to manage it[5]. Not only does the damage done by verbal and psychological aggression itself clearly warrant action but in addition the point is often lost that incidents of what are sometimes referred to as 'lower levels of violence', e.g. verbal abuse, intimidation and threatening behaviour, often precede, or signal, those circumstances where overt physical violence is more likely to follow[8]. Valuable points of intervention are therefore missed when purely physical violence is the sole target of action. Notwithstanding any theoretical and practical link between them, the fact remains that, while actual physical assaults can and do take place in Healthcare settings, verbal aggression and threats of violence are much more common than physical forms of violence[11].

There are a number work features which put Healthcare workers at risk. For example, workers often have to interact with members of the public who are in pain and with service users who feel anxious when accessing Healthcare services. On occasions staff may have to deliver bad news that confirms service users' worst fears. In some situations, Healthcare workers have to manage

those with, for example, problems of anger control or deal with those under the influence of alcohol and/or other drugs. Whilst this list is not exhaustive it points to the almost inherent and intrinsic risk of violence that Healthcare workers face.

"there is something intrinsic in the nature of the work itself (Healthcare) which results in high risks".[3]

Text in parentheses added by the authors

1.2 MEETING THE CHALLENGE AND TACKLING THE PROBLEM

With the growing evidence of the scale of the problem and the damage it causes a number of strategic responses have been launched to meet this challenge. Initiatives and programmes have been instigated at both the 'local and national level' e.g. Welsh Assembly, Scottish National Executive, The Independent Sector, Security Management Service (SMS), National Institute for Clinical Excellence (NICE), National Institute for Mental Health in England (NIMHE) (see Box 3 for some examples).

What is clear from the positive action that is underway across the Healthcare sector is that there is no single solution to preventing workplace violence and aggression. Interventions to prevent and manage work-related violence must be considered within the broader context and framework of a total organisational response[12]. What is also clear is that training is often held to be a primary element of the strategy for combating work-related violence. Indeed for many Trusts and other Healthcare organisations, training programmes in 'conflict / violence management' are now an essential feature of organisational life. However, with the huge investment accorded to training in this area within the Healthcare sector the question is no longer "should we train?" but "is training worthwhile and effective?" On the state of the evidence published prior to this report, the answer to some extent was 'we don't really know'! But with the evidence gathered as a result of this research we now have a clearer understanding of the impact of training and a clearer appreciation of what effective training in violence management (i.e. in terms of content and design) actually looks like.

Examples of positive action to tackle workplace violence and aggression at the national level across the Healthcare sector

Security Management Service (SMS): The SMS, part of the Counter Fraud and Security Management Service (CFSMS), was launched on 1st April 2003. The SMS has the operational and policy responsibility for reducing violence and security in the NHS. Key elements of the strategic aims and actions of the SMS include the launch and delivery of various national programmes of training on conflict resolution for all NHS staff, a new national reporting system to record incidents of physical assault, a new Legal Protection Unit to increase the prosecution rate and the development of local security management specialists.

National Institute of Clinical Excellence (NICE): The National Institute for Clinical Excellence (NICE) has issued guidelines for the NHS on the management of disturbed/violent behaviour in psychiatric inpatient settings and emergency departments. The guideline provides a comprehensive framework for how to assess risk and prevent violence, de-escalate and calm down a potentially violent situation and intervene safely when violence occurs.

National Institute for Mental Health in England (NIMHE): Through a joint initiative between NIMHE and the National Patient Safety Agency guidance has been published with regards to developing positive practice standards with regards to safe and therapeutic management of violence and aggression.

Welsh Assembly Government and NHS Wales: The development of the 'All Wales NHS Violence and Aggression Training Passport and Information Scheme' which provides a framework for the delivery of violence and aggression management training within the NHS in Wales. It also provides guidance on the development of documentation to ensure the effective assessment and management of violence and aggression. The overall aim of the scheme is to ensure consistent standards of documentation and training within the NHS, reducing the need for re-training and saving in training time and resource.

Scottish Executive and NHS Scotland: Seminal consultations and publications have helped to launch strategic and coordinated action across Scotland's Healthcare sector in tackling workplace violence. In particular, guidance on managing health at work was launched in 2002 and a host of other campaigns have been launched to raise awareness of and the lack of tolerance to violence and aggression towards staff.

ZERO Tolerance Campaign: Launced in 1999, this was a campaign specifically aimed at increasing staff awarness of the need to report, assuring staff that this issue would be tackled and informing the public that violence against staff working in the NHS is unacceptable and would be stamped out. Importantly, one of the key functions of the NHS zero tolerance zone campaign is to provide a mechanism for sharing good practice on dealing with the problem of violence against staff working in the NHS.

This list is not meant to be exhaustive but more reflective of the strategic initiatives and positive action which is taking place to manage and prevent violence across the Healthcare sector.

Box 3

1.3 THE ROLE OF TRAINING AND THE NEED FOR EVALUATION

The published report by the NAO (2003)[4] concluded that although there was evidence of training in violence management being offered to staff within Healthcare, there was little evidence based information regarding its effectiveness.

"the content of many training courses is determined by the preferences of the training provider rather than any real assessment of trainees' need; and there are few systematic and scientifically rigorous attempts to determine the impact of the training provided (*over and above the proverbial 'happy sheet' completed by delegates at the end of the training*)" (NAO 2003)[4].

Text in italics and parentheses added by the authors

With the continued investment in training, however, evaluation becomes an essential part of the process. It is no longer sufficient to rely on expert opinion and judgements of what is effective or ineffective training; all training must be evaluated and underpinned by evidence about its effectiveness. Evaluation of the effectiveness of training programmes is critical because, without it, for example, organizations have no good way to know whether training budgets are being spent wisely or whether training is meeting its stated objectives. In addition, it is important for any organisation to recognise whether the intervention prescribed (i.e. training in violence management) is suitable for the problem that has been diagnosed. There is real value, then, in undertaking training evaluation, not least because only proper scientific evaluation can prove whether or not a training programme has worked (see Box 4 below).

The benefits of evaluating training

- **To ensure training meets important organisational benefits.**
- **To assess staff reactions (satisfaction) about elements of the training.**
- **To determine whether learning has taken place.**
- **To ensure the best available and most cost-effective designs are used.**
- **To ensure the most appropriate methods of delivery are being utilised.**
- **To assess whether or not training is used on the job (*transfer*).**
- **To determine what is supporting or hindering the transfer of learning.**
- **To examine the impact training has had on important organisational outcomes.**
- **To determine the return on the training investment.**
- **To ensure training content is improved and updated with latest research evidence and thinking.**

Non Exhaustive

Box 4

Why evaluate is, however, only one of the key questions that must be answered. The second equally crucial question is ***'what should training evaluations evaluate'?*** Obviously a reduced exposure to incidents of violence would be a potential starting point. But this isn't as easy as it

sounds, because it is often found that staff are more willing to report incidents following their attendance at a violence management programme of training; training often has the effect of legitimating the topic and reducing barriers to reporting. But given the damage that it does to many aspects of health and well-being, it is important that multiple indicators of health and well-being (e.g. measures of work attitudes and general well-being) are considered as important additions to any efforts to evaluate training.

Although the case can be made to evaluate training on a variety of criteria, a key measure of the success of any training programme is the extent to which a delegate exits the programme with a perceived ability, confidence and self-assurance that they have the necessary knowledge, skills and understanding to be able to deal and cope with the conflict situations that they might face in the work environment. To date there is a relative paucity of well-designed evaluation studies into the effectiveness of the training to prevent and manage violence in Healthcare settings. While previous evaluation research has reported some encouraging results their findings are limited for a number of serious reasons[13-17]. First many of these studies are limited by their small size and/or the lack of an appropriate control group. These make the true effects of the intervention programme difficult to interpret. Second, it is impossible to make generalisations on the basis of these studies with respect to the content and structure of effective violence management training. In part, at least, this is due to the simple fact that the majority of evaluation studies never attempt to assess the content of training and certainly not in a way that allows comparison across different violence management programmes against a common framework. The development of such a framework was one of the aims of the current research. An important step forward in terms of conducting training evaluation research is not only to gather reliable and valid evidence but to enable such evidence to be translated into usable guidance regarding the content design and delivery of violence and aggression management training; also an aim of this research.

1.4 THE SCOPE AND OUTCOMES OF THE RESEARCH

The objectives of the research were as follows:

1. To examine a broader range of outcomes against which the effectiveness of violence management training can be assessed.

2. To produce an evidence-based evaluation of the effectiveness of current violence management training programmes.

3. To establish how violence management training ‘works’ (i.e. the content of training) in terms of its impact on the broader range of criteria.

In addition, the scope of the research was to:

4. To develop a general suite of tools and instructions for their use, covering:

    a) Assessment of training needs and the extent to which available training meets them;
    b) The evaluation of training; and
    c) An analysis of current provision against best practice standards.

5. To develop a best-practice monitoring tool to inform those with a responsibility for assessing violence management training programmes by way of conducting a gap analysis of the training provision.

6. To provide a set of instructional case studies in the 'best practice' management of violence and aggression.

1.5 FOCUS OF THIS REPORT

Section 2 of the report provides background information about the research design and approach to the evaluation of training across the Healthcare sector (***Objective 1***).

Section 3 and section 4 of the report document the evidence from the evaluations of the various training programmes examined (***Objective 2***).

Section 5 of the report provides a closer examination of the content of training and presents evidence on the impact of the training programme content design on the criteria against which training was evaluated (***Objective 3***).

Section 6 of this report summarises the key findings and presents the key messages from the research and offers best-practice guidance with respect to the design, delivery and evaluation of training in this area.

1.6 TOOLS AND CASES STUDIES

To support this research report is a second companion practitioner report. The practitioner report contains information and tools to support the design, delivery and evaluation of violence management training. It also contains several case studies reporting on violence management training within the Healthcare sector. The practitioner report supports the delivery of **Objectives, 4, 5 and 6**. The overall aim of the tool-pack and case studies is three-fold: 1) to raise awareness of the importance and benefits in assessing training needs and evaluating training; 2) to support this need for action by providing the necessary tools to enable a basic assessment of training needs and enable evidence to be gathered regarding the effectiveness of training; and 3) to develop a common framework (*language and process*) for the assessment of training needs and the evaluation training.

More specifically, the objectives of the tool-pack and case studies will be to assist in the assessment of training needs and in the evaluation of training. The tool-pack is designed for anyone with an interest in designing, delivering and evaluating violence management training. The tools will also support the role of any regulatory, advisory or enforcement agency (e.g. HSE, SMS, Healthcare Commission, and others) in assessing the training provision across Healthcare settings. The case studies aim to support and develop thinking about violence and aggression management training in general. They will provide real examples of action taken within the sector and outline the key issues and lessons learned.

The overall aim of the main research report, the tool-pack and the case studies is not only to support the need for improved quality and standards but to foster communication and collaboration between organisations. There is a genuine need for coordinated thinking and action

planning to enable sustainable and valuable change in solving and minimizing impact of hazards such as workplace violence. This community-based approach will assist in the future development of innovative and transferable solutions supporting and changing the way we attempt to tackle, manage, prevent and learn from such issues.

2. ASSESSING THE IMPACT OF TRAINING

2.1 RIGOROUS AND SYSTEMATIC EVALUATION

The majority of existing 'evaluation studies' on violence management training, whether in Healthcare or other sectors, are seriously devalued due to a number of fundamental flaws:

- A sole or primary reliance upon the subjective and superficial post-training assessment of what are little more than surface level reactions to the training, e.g. the so-called 'happy sheet'.
- Utilisation of poor research designs which do not allow accurate assessment of (a) the degree of change taking place over the duration of training, (b) whether such change lasts or transfers back into the work environment, or (c) whether or not any change that occurs is really due to the training or to some other, as yet unidentified, factor(s).
- Small research samples, which make generalisation of any results misleading and erroneous.
- Utilisation of a narrow and impoverished range of outcome variables against which the impact of training is to be assessed.

Without the necessary evidence base, the real impact of violence management training is likely to remain unknown. However, without knowledge of its impact, there is little or nothing of substance upon which to determine the content or curriculum of training. In short, the content of training must be validated – and hence justified - against empirical evidence of its impact.

The key question then is how do you obtain the required reliability and validity of the evidence? The best way to guarantee the quality of the evidence is through the use of rigorous and systematic data gathering (i.e. the application of a scientific method). In simple terms, the evidence gathered needs to make use of some degree of assessment before and after training, to enable an assessment of change due to training. In an ideal scenario some kind of control or comparison group would also be used in order to determine whether or not any change taking place is attributable to the training itself.

Figure 1 below sets out one of the most rigorous designs that can be utilised in research-based evaluations. As indicated in the diagram (see Figure 1) delegates for training are typically assessed immediately before the training begins. They are then reassessed again at the end of the training programme. A follow up assessment three months post training addresses two important questions: 1) does any effect of training last and 2) does the training transfer into work practice. The control group indicated in Figure 1 should comprise an 'equivalent' group of staff who are not currently undertaking training.

In this most rigorous training evaluation design employees are randomly assigned to either a 'to be trained' or 'not trained control/comparison' group for the duration of the research study. However, nowhere other than in very controlled or highly structured environments can the application of this design become a reality.

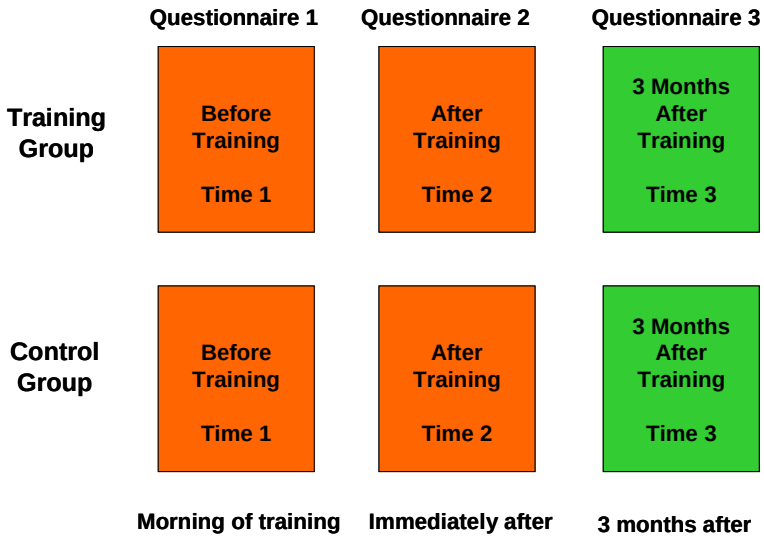

Figure 1 The evaluation design to enable comparisons to be made between being trained and not being trained

In conducting organisational research one is continuously reminded of the very real constraints associated with the application of any formal experimental designs such as that schematically presented above. The utilisation of the pure experimental design method is often not feasible on both practical and moral/ethical grounds. Practically, it would have been an insurmountable obstacle (i.e. due to organisational differences, operational constraints associated with cancellations and high attrition rates) to attempt to achieve true experimental assignment of staff to either a training or control group for the duration of the research. In addition, and more importantly, morally and ethically it was not perceived to be safe and/or effective research practice to randomly assign staff to either a 'to be trained or control' group especially when violence management training is deemed to be mandatory. There is also a very real danger of assigning individuals in critical need of such training (i.e. from high risk groups) to a non trained control group. In the event of such a stringent 'experimental design' being made a condition of this research it would have, in the best case scenario, resulted in an extremely constrained sample and, at worst, would have jeopardised the entire research study.

Given the realities of the training world a decision was taken to adopt a more flexible research design based on variants of the design outlined above in Figure 1. The use of a flexible evaluation design looked to minimise any threats to the internal validity of the research (i.e. is any change found due to training) whilst maximising the ability to establish statistical conclusion validity (i.e. is there a difference between being trained and not being trained). This line of thinking is well documented and is technically supported by scholars and practitioners in this area who argue that those who analyse training should choose the most rigorous design possible and be aware of its limitations[18.] Alternative design approaches were also used in the research, an example of which is shown in Figure 2 below.

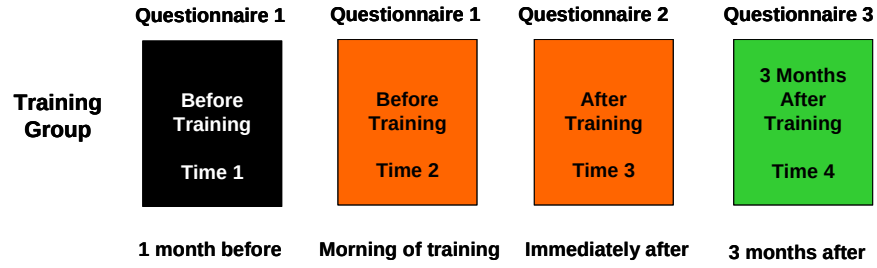

Figure 2 A variant of the evaluation design to enable comparisons to be made between being trained and not being trained

On those occasions where a control group could not be obtained, data were gathered from training group participants alone. The overall sample size of the training group (i.e. 1000+ cases) that thereby resulted in this research helps to mitigate against any weakness in the data that the lack of a control group might have otherwise presented. There is growing evidence from statisticians that the pursuit of a control group in evaluations can actually reduce the power of the analysis if that pursuit results in a very small overall sample size[19]. In short, it is the sample size of the training group that is fundamental, with a pre and post assessment of a large number of trainees being the key.

The quality of this data set is therefore assured by:

1) The use of comparison group drawn from other organisational members of staff where available;
2) The use of multiple pre training assessments where available. Here the trainees become their own control group in the sense that what happens during training can be compared with what happened in the period before they attended training; and
3) The large sample size of the training group overall, the size of which is extremely rare in evaluations of this kind.

3. AGAINST WHAT CRITERIA DO WE EVALUATE AGGRESSION AND VIOLENCE MANAGEMENT TRAINING?

3.1 CAPABILITY AS A KEY CRITERION

As the titles of some of the courses currently on offer testifies, violence management training comes in a variety of forms. Despite this breadth in content and focus, all violence management training ought to share a common purpose, i.e. empowering Healthcare staff to deal with those incidents of verbal abuse, intimidation, threat or actual physical assault and attack that, sadly, they may have to face in the course of their work. In short, on completing a training programme, staff should feel more capable of dealing with, or handling, incidents of aggression and violence than they did before attending the training.

With respect to handling or managing incidents of aggression and violence, capability has a number of facets, some of which reference our own individual efforts, while others focus more on how we judge the ability of our colleagues, managers and the organisation as a whole to work to protect our safety. Capability, in other words and as shown below in Figure 3, can be thought of in two related but distinct ways, i.e. as a matter of one's own individual capability and as a matter of collective or organisational capability.

Figure 3 to show the two levels of capability

Five specific aspects of perceived capability were identified and assessed as part of the evaluation exercise see Table 1 below; 3 at the individual level and 2 at the collective. The decision to use perceived capability as a benchmark against which to judge the impact of violence management training is not just a matter of self-evident logic. A broad range of research findings are known to point to a powerful link between perceived capability and a range of health and behavioural outcomes, e.g. anxiety, stress, commitment to what we are doing and our level of motivation[20].

Table 1 Describing the measures of capability at the individual level

INDIVIDUAL	1. The perceived capability of the individual him/herself to deal with verbal abuse originating from colleagues, managers and other staff (shortened to **PCVAI**).
	2. The perceived capability of the individual him/herself to deal with verbal abuse originating in a variety of situations and contexts to do with service users (shortened to **PCVAE**).
	3. The perceived capability of the individual him\herself to deal with a physical attack originating in a variety of situations and contexts to do with clients, patients and other members of the public (shortened to **PCPA**).
COLLECTIVE	4. The individual's assessment of their colleagues' and/or line manager's capability to come to their assistance during an incident and to be sympathetic and supportive afterwards (shortened to **CCP**).
	5. The individual's more general and broader assessment of the organisation's capability to tackle violence, e.g. through the provision of training and the value and purpose put on reporting procedures (shortened to **CCD**).

The value of using perceived capability in dealing with aggression and violence as a measure of training effectiveness was therefore gauged in three ways (this analysis process is also represented diagrammatically in Figure 4 below):

Q1. By assessing the strength of the association between the five identified aspects of capability and a range of health and attitudinal outcomes before training began (see Figure 4).

Q2. By assessing the extent to which pre-training levels of capability in these five areas are related to levels of these same outcomes three months later, i.e. at the point of follow-up (see Figure 4).

Q3. By assessing whether pre-training levels of these five aspects of capability are related to later levels of the outcomes even when pre-training levels of the outcome are statistically accounted for (see Figure 4).

Each of these three steps represents a sequentially more stringent test of the value of perceived capability as a common standard or benchmark against which to judge the impact and effectiveness of violence management training. Where the first step simply examines whether or not health, well-being, work attitudes and behavioural intentions "go together with" perceptions of capability in dealing with aggression and violence, the second examines the strength which capability predicts them. The final and most exacting test explores the extent to which capability predicts any in change health, well-being, work attitudes and behavioural intentions.

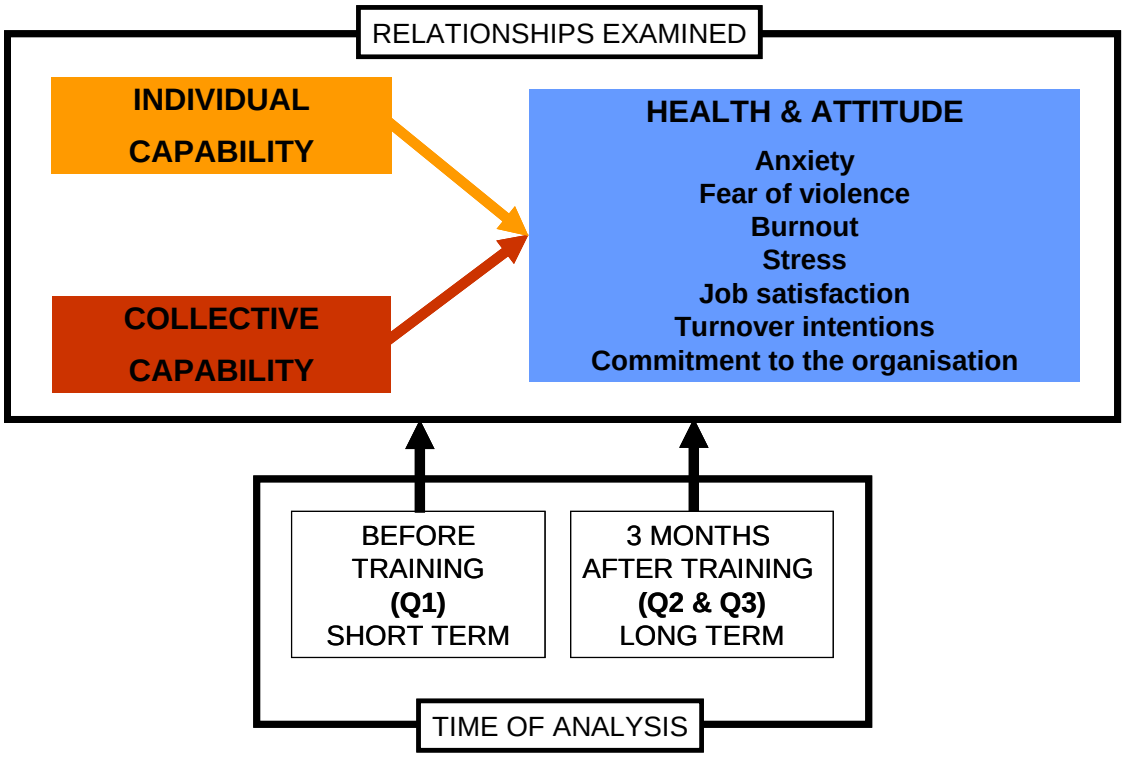

Figure 4 The analysis process between capability, attitude and health outcomes

However, these capability dimensions were not the only criteria that were used to judge the impact of training (see Section 4). In addition, the overall effect of training was also judged in terms of its impact on:

1. Anxiety about the possibility of personally experiencing some form of violence and aggression while at work; and
2. Fear of violence.

The training was also assessed in terms of what are now known to be three more reliable and important post training reaction measures these included:

1. The extent to which trainees enjoyed the training (or course);
2. The extent to which trainees thought the content of training had practical utility and was transferable to the workplace; and
3. The extent to which trainees found the training content difficult.

Table 2 below summarises the strength of the association prior to training between elements of individual and collective capability identified and important health and attitudinal outcomes as shown in Figure 4 above.

Table 2 Summarises the effect of reporting higher levels of individual and collective capability on seven important outcomes before training

The Impact of Higher Levels of Capability on Outcomes	HEALTH & ATTITUDE OUTCOMES						
	Anxiety	Fear	Burnout	Stress	Job Satisfaction	Turnover	Organisational Commitment
PCVAI				↓			
PCVAE	↓		↓	↓	↑	↓	↑
PCPA	↓						
CCP			↓		↑		
CCD		↓	↓	↓	↑	↓	↑

Table 2 Key (How to interpret this table)

- An upward arrow means that there is a positive and statistically significant relationship between the concepts (i.e. as scores on one variable increase so scores on the other variable increase)
- An downward arrow means that there is a negative and statistically significant relationship between the concepts (i.e. as scores on one variable increase so scores on the other variable decrease)

This table outlines the positive impact (e.g. relationship) of higher levels of capability on the health and attitudes outcomes measured. For example, the table shows that those who have a higher sense of capability to deal with violence and aggression from service users (PCVAE) also have lower levels of anxiety, burnout and stress, and are less likely to quit the organisation (*turnover*). In addition, those who report higher levels of PCVAE also report higher levels of job satisfaction and commitment to the organisation.

Not only does Table 2 demonstrate the important bearing that capability can have on both individual and organisational health it also points to the importance of two particular aspects of it, one an element of individual capability and the other the assessment of organisational capability (*as highlighted in grey in Table 2*). What's more these same two components of capability were each in turn related to reduced anxiety about attending the training itself, increased motivation to learn and increased confidence about one's ability to learn (see Box 5).

Relationship between capability and trainee characteristics

▼ **Reduced anxiety about training**

▲ **Increased motivation to learn**

▲ **Increased confidence in ones ability to learn**

Box 5

In terms of pre course levels of capability predicting individual and organisational well-being three months later, the key finding from the data was that it is collective rather than individual capability which has the greatest positive impact. Specifically, higher levels of collective capability predicted lower levels of burnout, fewer symptoms of stress, increased job satisfaction, lower intentions to leave and higher commitment to the organisation (see Box 6).

Long term effects of collective capability on well being

▼ **Lower levels of burnout**

▼ **Fewer psychological symptoms of stress**

▲ **Increased job satisfaction**

▼ **Lower intentions to quit**

▲ **Higher commitment to the organisation**

Box 6

Moreover, for burnout and intention to quit, pre course measures of perceived capability predicted burnout and intention to quit three months hence even when the initially assessed levels of burnout and intention to quit were statistically controlled for.

All in all what this series of results demonstrates is 1) the critical role perceived capability in dealing with violence and aggression plays in influencing individual and organisational well-being and 2) its power and appropriateness as a benchmark criteria against which to judge the impact and effectiveness of violence management training. All of the training courses that were evaluated in this research were therefore assessed, as a minimum, in terms of any change they brought about in these five elements of capability.

4. WHAT IMPACT DOES TRAINING HAVE ON PERCEIVED CAPABILITY AND OTHER IMPORTANT CRITERIA?

4.1 WHAT HAPPENS IN GENERAL OVER THE COURSE OF TRAINING?

This was gauged by comparing pre (*before*) and post *(after)* scores for the training group with those of the control group. If training has any generalized effect then the amount of change in the training scores should exceed that in the control group. This analysis was done for each of the following variables:

- Anxiety about the possibility of personally experiencing some form of violence and aggression while at work.
- Fear of violence.
- PCVAI (the perceived capability of the individual him/herself to deal with verbal abuse originating from colleagues, managers and other staff).
- PCVAE (the perceived capability of the individual him/herself to deal with verbal abuse originating in a variety of situations and contexts to do with service users).
- PCPA (the perceived capability of the individual him\herself to deal with a physical attack originating in a variety of situations and contexts to do with clients, patients and other members of the public).
- CCP (the individual's assessment of their colleagues' and/or line manager's capability to come to their assistance during an incident and to be sympathetic and supportive afterwards).
- CCD (the individual's more general and broader assessment of the organisation's capability to tackle violence, e.g. through the provision of training and the value and purpose put on reporting procedures).

The results of this analysis are summarised below and shown diagrammatically wherever there was a ***significant change or difference*** (for ease of interpretation this term is explained below in Box 7).

Explaining the term significant difference

The significance level tells you how likely it is that an observed result might be found by chance. The questions is, 'how low should this likelihood be in order for us to conclude that the observed result is likely to generalise to other people comparable to those in our sample?' If a result is likely to generalise, then we can consider it robust and reliable and therefore meaningful. Conventionally, a threshold point of 0.05 (five times out of a hundred, or one chance in twenty) is set as the cut-off point for demonstrating statistical significance. In other words, if the probability of an observed result occurring by chance is one in twenty, or less, then it is 'statistically significant'. Any 'statistically significant' findings referred to in this Report have achieved at least this 0.05 threshold. Often, they have an even lower likelihood of being found 'by chance' (e.g. one in a hundred, or one in a thousand).

Box 7

The results of this analysis showed:

- **Anxiety** about violence fell to a greater extent in the training group this effect is illustrated in Figure 5 below. [1]

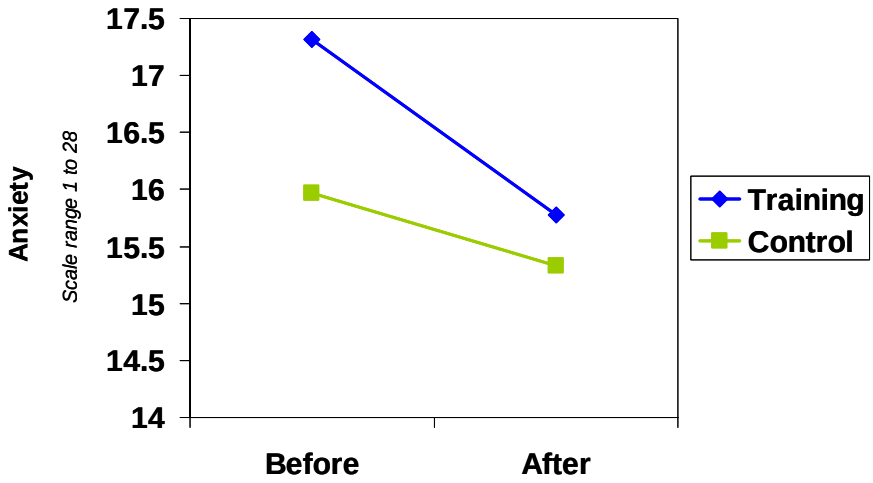

Figure 5 Comparing changes in anxiety before and after training

- There was no difference between the training and control group in **fear of violence**.
- **PCVAI** rose in the training group and fell slightly in the control group as shown in Figure 6.

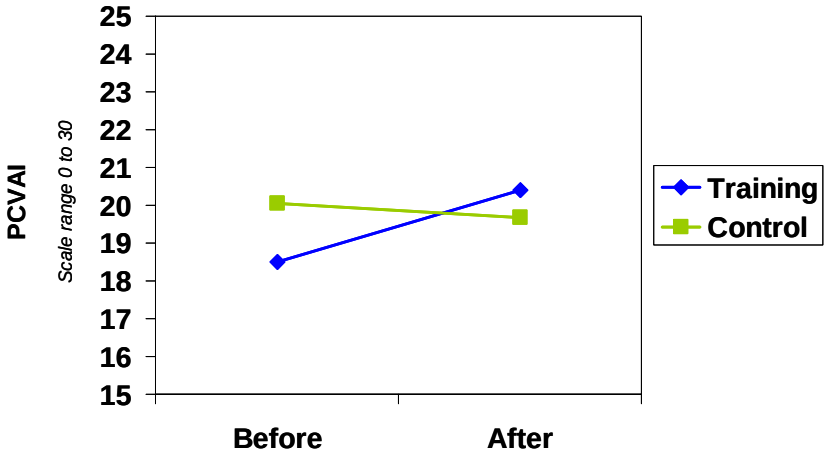

Figure 6 Comparing changes in PCVAI before and after training

[1] Within the overall data set were 80 cases from whom two pre-training assessments were available. This allowed for an analysis of what happens to anxiety levels in the month prior to training. In fact anxiety levels rose significantly over this month. In effect any fall in anxiety over training is simply returning anxiety to its original baseline

- **PCVAE** showed a very similar pattern as *PCVAI* illustrated in Figure 7.

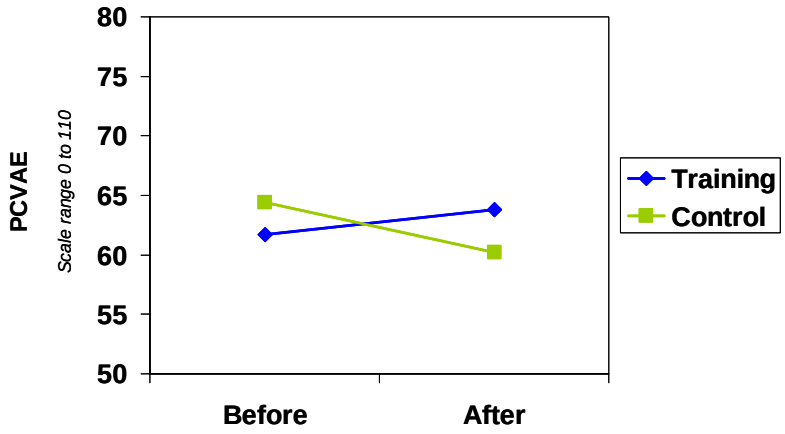

Figure 7 Comparing changes in PCVAE before and after training

- **PCPA** showed a marked increase in the training group but remained relatively static in the control group as shown below in Figure 8.

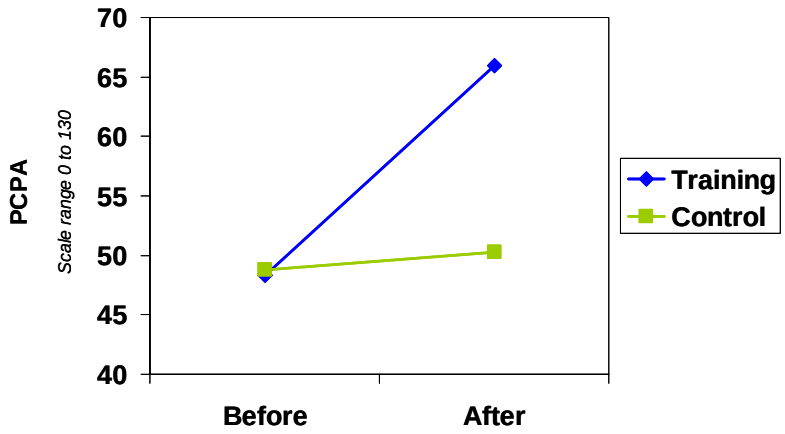

Figure 8 Comparing changes in PCPA before and after training

- There was no change in the difference between the training and control group on **CCP**.

- **CCD** showed a greater rate of increase in the training group than it did in the control group see Figure 9.

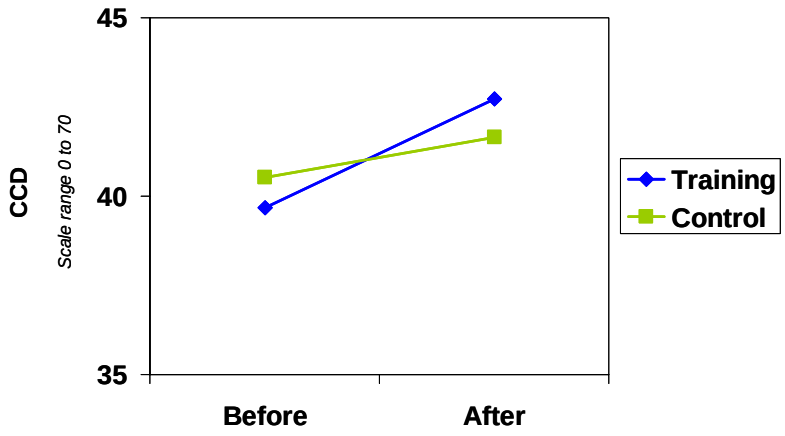

Figure 9 Comparing changes in CCD before and after training

4.2 DO THE BENEFITS OF TRAINING LAST?

Irrespective of the amount of change that takes place during a training course the fundamental question is **does this change last?** Or put another way; **are any benefits of training lost over time?**

This question was answered by comparing scores three months post training with those recorded immediately after training for all cases where this matched data was available. This comparison was undertaken for each of the following variables:

- Anxiety
- Fear of violence
- PCVAI
- PCAVE
- PCPA
- CCP
- CCD

The results of this analysis are summarised below and shown diagrammatically wherever there was a significant change or difference.

The results of this analysis showed:

- Levels of **anxiety** remained relatively static from post training to follow up.
- Levels of **fear** showed almost no change at follow-up.
- **PCVAI** *fell* significantly at follow-up as illustrated below in Figure 10.

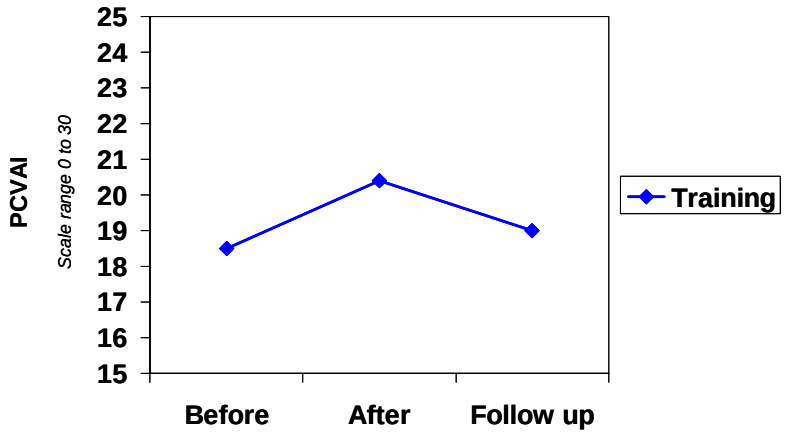

Figure 10 Examining changes in PCVAI at follow-up

- **PCVAE** remained at the same level (at follow-up) as it was post course (immediately after training).
- **PCPA** *fell* significantly in the three months post training as shown below (see Figure 11).

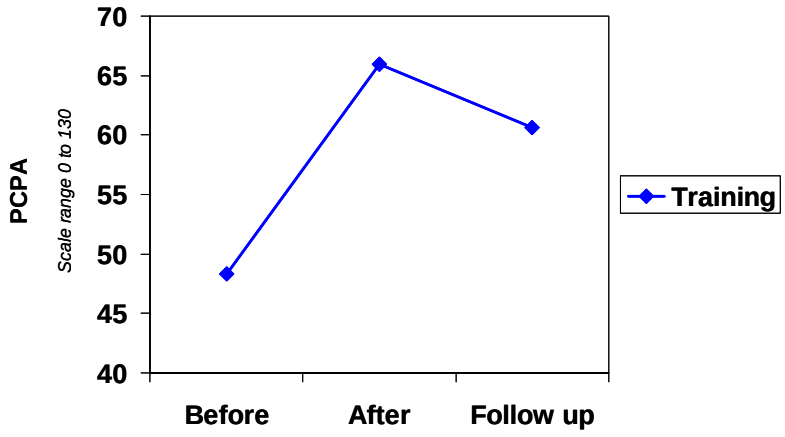

Figure 11 Examining changes in PCPA at follow-up

- **CCP** showed no marked change from post course levels.
- **CCD** *fell* significantly in the period following training as illustrated below in Figure 12.

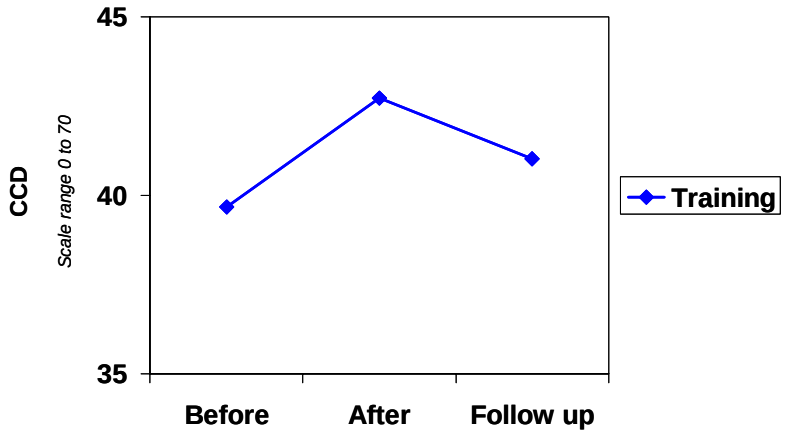

Figure 12 Examining changes in CCD at follow-up

What is clear is that any benefit of training is largely lost within a matter of months. This raises two fundamental questions that, to be answered in detail, extend beyond the scope of this research but nevertheless they do require answers to improve the nature and quality of training in this domain. First '***is the short lived and curtailed benefit of training a matter of training design?'*** e.g. of the failure of many training courses to adequately address issues which feed into specific areas of capability. Or second, '***is it a case that the input of training itself is extremely limited unless training is contexualised and supported by a range of other interventions within the organisation?***' Section 5 of this report begins to address these questions and presents research evidence of how training can be designed to better develop and enhance staff capability in dealing with violence and aggression.

5. WHAT IS IT ABOUT THE CONTENT OF TRAINING THAT DIFFERENTIATES HIGH FROM LOW IMPACT TRAINING?

5.1 HIDDEN DIFFERENCES BETWEEN COURSES

So far we have discussed the general and limited but positive impact of training on the criteria outlined. However, the assessment of the general impact of training (i.e. grouping all the different Healthcare organisations together to achieve large numbers in the analysis of the data) tends to mask more sensitive differences between the training programmes. The next key question to answer is ***'whether any particular profile of training in terms of its content has more or less of a positive impact on the key criteria outlined above?'*** In short, the content of training must also be validated, and hence justified, against empirical evidence of its impact.

At the outset of the research we undertook a series of focus groups with a range of experts across the United Kingdom (UK). These focus groups were convened to answer the question of what, in general and in best practice terms, should the content of training programmes in violence management comprise. The experts were also asked to consider the different types of Healthcare setting when providing their responses to the above question. The response in all of the focus groups was that, although in some settings the degree of emphasis on certain elements of training may be greater there are key content areas which should be emphasised regardless of setting. As a result of the focus group process, and a series of data sifting and grouping exercises, six key broad areas of training content were identified as shown in Table 3 below:

Table 3 Outlining the six content areas against which training was assessed

Content Topic	Content Description
Legal Context	Understanding the legal context (including, the right to protect yourself and the use of reasonable force)
Models of violence	Information and models about why and how violence occurs (including, defining violence)
Non Physical Skills	Non-physical management of violence (including, customer care, diffusion/de-escalation, verbal communication skills, non-verbal skills, cultural diversity)
Physical Interventions	Physical intervention/management skills (including, breakaway and control & restraint techniques)
Organisational Policy & Procedures	Organisational policy, procedures and practices in relation to work-related violence (including, roles and responsibilities of management and staff, reporting and emergency action plans)
Post Incident Reactions	Post-incident reactions and support (including, how you might feel after an incident, how to get help internally and externally)

Using the six key content areas as a guide, a closer look at the content profiles of each of the training programmes evaluated in this research was undertaken. This was achieved by:

1. First, examining the amount of change in physical capability over training. Change in physical capability was chosen on the ground that with one exception all of the training courses evaluated placed a significant emphasis on some type of physical intervention skill.
2. Each Trust was then rank ordered in terms of the change in physical capability achieved.
3. Selecting and comparing the training content of the two Trusts where the greatest improvement in physical capability (High Change Group – HCG) was achieved with the two Trusts where the least improvement in physical capability (Low Change Group – LCG) was achieved.[2]

As a result of the ranking process it was found that the two organisations with the greatest amount of change in physical capability were from Acute General Trust settings and those with the least amount of change were from Mental Health Trusts. Therefore, and before any comparison could be made of the content profiles and the impact of these training programmes, it is important to ensure that there are no differences between the groups before any training takes place on the key criteria as well as on other measures known to influence the impact of training. The two groups were therefore compared on the following criteria before any training had taken place:

- PCVAI
- PCVAE
- PCPA
- CCP
- CCD
- Gender
- Tenure
- Age
- Whether or not they had received previous instruction in this area
- Whether of not they had been exposed to violence and aggression (physical and verbal)
- Importance ratings of the six content areas

With one exception, there were no differences between the two groups on any of the above outcomes (e.g. demographics, initial capability, exposure to violence and aggression or content importance ratings). The only dimension on which the two groups did differ was in terms of whether or not they had received previous training in the management of violence.

When the analysis was carried out again using only those participants from the two groups who had received previous training, there were no differences between the two groups. Therefore all subsequent comparisons between the groups in terms of the impact of training were conducted using only those cases in the two groups who had received previous training in this area and comprised:

[2] The decision to compare the 'top' two and 'bottom' two Trusts was taken on primarily pragmatic grounds. Reliance upon a single top and bottom Trust was rejected on the grounds that this might reveal only a Trust effect rather than a training effect. This danger is mitigated by having two Trusts in each group while at the same time preserving the greatest distinction between high a low change training. In reality however, subsequently analyses of groups 3, 4 and 5 Trusts at each end of the distribution revealed a primarily similar picture but at lower levels of statistical probability.

4. Examining whether there were any differences in the two groups (HCG vs. LCG) in terms of the impact of training (i.e. the amount of change) upon the key criteria (i.e. PCVAI, PCVAE, PCPA, CCP and CCD).
5. Examining whether any differences between the two groups on the key criteria could be explained by the general profile of training content by comparing the selected two groups in terms of:

    a. How important staff perceived the six content areas to be in helping them in their work?; and
    b. How much emphasis was placed on any of the six content areas during training?

Figure 13 highlights the level of change in the key criteria across the two groups.

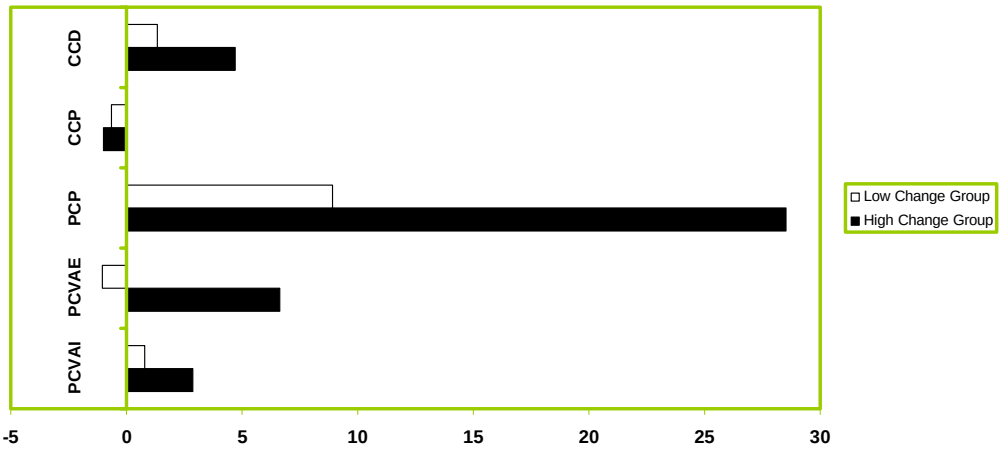

Figure 13 Comparing the level of change in the key criteria in the high and low change groups

The results of this analysis are summarised below:

- There was a greater positive change in the High Change Group (HCG) in terms of capability in dealing with verbal abuse from other colleagues (PCVAI) than in the Low Change Group (LCG).
- There was a greater positive change in the HCG in terms of capability in dealing with verbal abuse from external service users (PCVAE). In the LCG there was a negative change which means that participants had a lower level of capability at the end of training in comparison to their starting levels of capability.
- There was a greater positive change in the HCG than in the LCG in terms of their capability in dealing with physical attacks (PCPA).
- There were no differences between the two groups in terms of change in assessments of colleagues and/or line manager's capability to come to their assistance during an incident and to be sympathetic and supportive afterwards. In addition, and in both groups, there was a negative change in CCP which means that participants perceived themselves to have a lower level of capability at the end of training in comparison to their starting levels of capability.
- There was a greater positive change in the HCG than in the LCG in terms of the more general and broader assessments of the organisation's capability to tackle violence (CCD), e.g. through the provision of training and the value and purpose put on reporting procedures.

Analysis of the general profile of training provided a clear indication and explanation as to why such positive effects were realised in the HCG in comparison to the training provided by the LCG. These profiles are shown diagrammatically below in Figure 14.

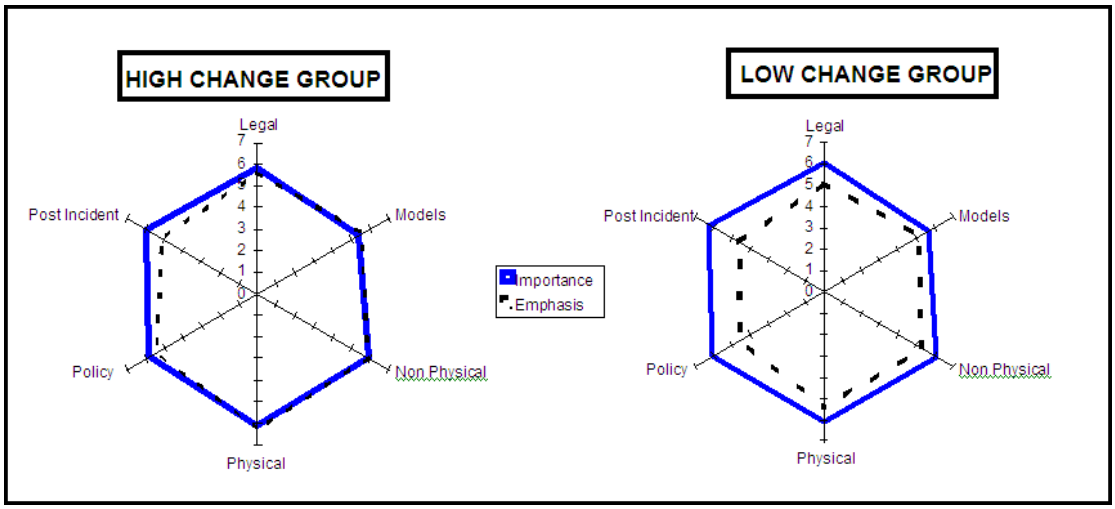

Figure 14 Shows the degree of match between importance and emphasis of the content profiles of training in the high and low change groups

The training profile for the HCG is one which, on most of the key content areas, is closer to meeting the perceived needs of its participants as shown by the greater degree of overlap between the blue 'importance' rating (*or continuous line*) and the black 'emphasis' rating (*or dotted line*). In contrast, in the LCG it is evident that the perceived needs of staff (i.e. what they report as being important for them) are not being matched in terms of the emphasis given to these content areas during training.

The national research findings indicate that training which is designed with the broader organisational context in mind (i.e. does not focus solely on the development of individual skill) tends to result in more beneficial outcomes in terms of enhanced capability (at both individual and organisational levels). The design and delivery of violence management training which is embedded within the organisational context is therefore more likely to have beneficial consequences, at both individual and organisational levels, in terms of reduced symptoms of stress and burnout, increased levels of job satisfaction and greater levels of commitment to the organisation.

6. WHAT DOES ALL THIS MEAN FOR TRAINING IN VIOLENCE AND AGGRESSION MANAGEMENT?

6.1 SUMMARY OF KEY FINDINGS

In general, training in violence management across Healthcare organisations[3] is having positive, but limited, short term benefits. It is fundamental to the success and effectiveness of such training that programmes are designed or selected and delivered on the basis of a sound understanding of what is actually needed. What is clear from the research is that where training does not reflect a sound understanding of need the impact of training is at best negligible and at worst negative (i.e. staff are leaving training feeling less capable in dealing with violence and aggression in the workplace).

This research has demonstrated that training has the greatest degree of impact (i.e. change) and value (i.e. contributing to the protective sense of health and well-being) when the knowledge and skill topics emphasised within the overall programme are situated within the broader context of the organisation in terms of its systems and procedures to prevent and manage violence and aggression (see Box 8 below which highlights some of the elements that make up the organisational context). Often the focus of training is on the development of individual competence in terms of skills, and in most cases physical skills. This can often increase participant anxiety and suspicions of the need for training and lead to feelings of insecurity and feelings of having to cope alone when it comes to dealing with violence and aggression in the workplace. All training in this area must be situated within the broader context of the organisation and not just emphasise the development of key skills. It is important that training also communicates and demonstrates the positive and supportive actions and outcomes of the organisation in general (see Box 8 below).

There is a fundamental and integral role for the concept of capability in both research and practice aimed at better understanding, managing and preventing workplace violence and aggression. This research has served to demonstrate this by documenting 1) the critical role perceived capability in dealing with violence and aggression plays in influencing individual and organisational well-being and 2) its power and appropriateness as benchmark criteria against which to judge the impact and effectiveness of violence management training.

6.2 KEY MESSAGES AND RECOMMENDATIONS OF THE RESEARCH

There is undoubtedly a great deal of positive action being taken by numerous bodies and agencies at local and national levels. What is clear about the various schemes and initiatives launched, and the guidance published, is the underpinning aims and objectives to cultivate, maintain, support and inform shared purpose and best practice. Together they demonstrate the need for strategic action which is not focused on single point interventions (i.e. training) but adopts a broader perspective and intervention strategy in the successful prevention, management and reduction of workplace violence and aggression. With respect to strategic action the key messages from this research are as follows:

[3] Caution is always recommended when generalising from any research sample to the main population. Although every effort has been made to defend the representativeness of these research findings, the continued collection of evaluative data will add further confidence to these results.

What do we mean by the organisational context?

- Reporting procedures follow national guidance and are well publicised, clear and easy to follow.
- Staff are fully aware of reporting procedures.
- There should be no confusion about roles and responsibilities with regards to violence and aggression management and reporting (i.e. the role of the Local Security Management Specialist [LSMS] within NHS settings is key to this communication process).
- There are clear demonstrations about how reported information is used in terms of taking action across the organisation.
- The various measures and initiatives the organisation is taking to prevent, manage and tackle violence and aggression are well publicised.
- There exists within the organisation, and staff know and believe that it exists, a sympathetic ear; internally through colleagues or externally through the provision of other elements of support (e.g. counselling, etc.).
- Showing how the content of training is clearly customised and tailored to the circumstances of the organisation (or client group).
- Demonstrations that the organisation is taking action and progressing, is proactive and that learning is taking place.

Non exhaustive

Box 8

6.2.1 Common criteria: benchmarking positive practice

There is now a need for a common and evidence-based benchmark (i.e. criteria) against which the value and impact of all violence management training can be judged irrespective of its focus, content, delivery method, etc. Without a common benchmark it's difficult, if not impossible, to judge the value or effectiveness of one course or programme against another. However, the choice of the benchmark is not arbitrary. Rather it must be a criterion which furnishes valuable information in terms of both individual and organisational outcomes. In addition, the criteria must have a utility in terms of informing decision making about the design, delivery or indeed the continuation of particular forms of training. In large measure, the value of capability as a benchmark criterion is that in can deliver against all these requirements.

1. The criteria for assessing training cannot be a matter of surface level (e.g. reaction) responses, as these are 'fools gold', short-term in nature and are influenced by recent experiences which are likely to alter the current mood and emotion of the delegate (i.e. they are state dependent). It is necessary to involve deeper level phenomenon which link into other major issues in Healthcare (e.g. burn out, sickness absence, retention of staff, etc.) and enable the return on investment to be considered from several perspectives but discussed within a common language.

6.2.2 Training needs analysis, design and delivery

What we do know about 'good' training is that:

a. The content tends to be broader;
b. The content tends to be more closely allied to perceived need; and
c. The content needs to include evidence and a clear demonstration of a proactive organisational response to workplace violence.

2. Training content has to be examined and wherever necessary redress any imbalance in terms of content areas associated with positive benefits (i.e. the relative lack of emphasis upon both verbal intervention skills and ways and means of providing visible demonstrations of organisational systems). Whatever skills are advanced in training they must be contextualised within a broader remit of organisation systems and procedures.

3. A principal failing or shortfall in much de-escalation training is that the content is underpinned by inappropriate or inadequate models of human behaviour and interaction. The models of aggression and violence that underpin training need to be valid, usable and underpinned by research evidence on their effectiveness.

4. The design of training must address issues associated with the transfer environment. While there is no quick fix remedy for the lack of transfer the solution requires such things as improved trainee problem solving skills, closer correspondence between the content of training and the way the 'organisation works' and better management (e.g. integration) of the training function with other organisational systems.

6.2.3 Training evaluation

All training courses on violence management must be evaluated in terms of their impact against these deeper and more fundamental criteria. The criteria against which training is to be evaluated needs to be broader, more meaningful and add value in terms of indicating the impact of training on both individual and organisation health.

5. National programmes of training must also undergo rigorous, systematic and independent evaluations to ensure fitness for purpose and continued development of training programmes against evolving needs and challenges.

6. It is never enough to assume that any course 'meets the bill'. Accreditation of training programmes provides a sound benchmark against which training can be reviewed, however this does and should not exclude any training programmes from rigorous, systematic and independent evaluations. End user utility has to be the final arbiter of training effectiveness and not accreditation in purely educational terms.

6.2.4 Organisational learning and improvement

The underpinning rationale behind all aspects of training, training evaluation and indeed other aspects of the management of violence must be to do with continual individual / organisational learning and development and not a 'tick-the-box' enforcement / compliance agenda.

7. There must be a commitment to continuous learning and improvement from all stakeholders involved with the management of violence and aggression. Words in themselves do not constitute commitment whether at the level of organisational or national policy. Commitment must be visibly demonstrated. An organisation, for example, could visibly demonstrate a commitment to organisational learning by involving employee representatives in the development of its workplace violence policy. Equally any organisation demonstrates its commitment to tackling violence by rigorously, systematically and independently evaluating its own training and communicating any findings and resulting actions.

8. Training cannot and must not be seen as a standalone solution to violence. The measures taken to control violence and aggression must be considered within the wider context of an integrated organisational response.

9. The business case for training in violence management needs to be made more robustly. Evidence needs to be gathered with respect to the need for particular forms of training (i.e. specialist and non specialist) and this must be considered alongside other strategies for intervention.

6.3 FUTURE: RESEARCH AND PRACTICE

There is an increasing gulf between research and practice in the domain of workplace violence and aggression. This gap between research and practice has inevitable consequences that often lead to inefficient thinking, decision-making and problem solving.

Action must now be taken to examine the strategic research agenda within the Healthcare sector to examine cross-over links between existing and future research against the practicing needs. Without a joint-strategic research agenda, thinking and problem solving becomes so devolved and dissolved that communication and learning about, for example, common issues, best practice, and quality research achievements becomes difficult to realise.

A case in point is the issue of violence management training. What we have seen over the past few years is the inevitable consequence of many practitioners devising and delivering interventions without any accurate appreciation or consideration of scientific rigour and validation of their interventions. This lack of an accurate understanding can come at a great cost and a loss to the organisations that purchase and deliver such services for their employees or clients. One question we must ask ourselves is “for how long can we continue to operate in this ‘ad-hoc’ manner?” It is not uncommon to now hear about competing agendas within the same sectors, whereby, for numerous reasons; committees, organisations and other stakeholder groups come together to grapple with the question of how best to tackle this issue. We also see within individual organisations decision makers becoming increasingly confused about what they should or should not be doing, about whom they should or should not listen to and what is or is not available to them in terms of support and advice. The need for proactive and strategic action is upon us. To this end the following recommendations are proposed:

10. A national approach to the evaluation of training must be developed and implemented. There is a real need for an independent strategy for the evaluation of violence management training

that enables positive action at local levels but supports cross communication at the national level.

11. Consideration (and action taken) of more effective ways of communicating accrued research knowledge in this area to support the development, capability and enablement of all stakeholders within and between Healthcare organisations.

12. There is a need to build on the amount of activity taking place in terms of managing violence and aggression with a view of developing and managing a strategic agenda for research and practice.

13. There is a real need to develop a more informed and sophisticated understanding of what works and what doesn't work in terms of primary, secondary and tertiary interventions for workplace violence and aggression.

14. There is a need for a common vehicle to manage this continuous thirst for knowledge and practitioner based tools. A vehicle which can support and co-ordinate meeting the need in a strategic manner centred around ongoing and iterative developments founded on a shared agenda.

7. APPENDIX

Key to abbreviations to support interpretation of tables and figures

	ABBREVIATION	DESCRIPTION
INDIVIDUAL CAPABILITY	PCVAI	The perceived capability of the individual him/herself to deal with verbal abuse originating from colleagues, managers and other staff.
	PCVAE	The perceived capability of the individual him/herself to deal with verbal abuse originating in a variety of situations and contexts to do with service users.
	PCPA	The perceived capability of the individual him\herself to deal with a physical attack originating in a variety of situations and contexts to do with clients, patients and other members of the public.
COLLECTIVE CAPABILITY	CCP	The individual's assessment of their colleagues' and/or line manager's capability to come to their assistance during an incident and to be sympathetic and supportive afterwards.
	CCD	The individual's more general and broader assessment of the organisation's capability to tackle violence, e.g. through the provision of training and the value and purpose put on reporting procedures.
HEALTH & ATTITUDES	Anxiety	Anxiety about the possibility of personally experiencing some form of violence and aggression while at work.
	Fear of violence	Fear of violence provides an indication of how at risk staff believe they are of experiencing violence and aggression as well as how vulnerable they feel they are.
	Job Satisfaction	Job satisfaction refers to one's feelings or state-of-mind regarding the nature of their work. It may reflect numerous dimensions e.g. the quality of one's relationship with their supervisor, the quality of the physical environment in which they work, degree of fulfillment in their work, etc.
	Organisational Commitment	Organisational commitment refers to how committed one is to an organisation. It may reflect factors such as whether an individual identifies with the goals of the organisation, has a desire to remain as part of the organisation, the degree of effort/time invested, degree of loyalty, etc.
	Intentions to quit	Turnover intentions provide a reliable indicator of the extent to which an individual is seriously considering leaving an organisation or is actually engaging in quitting behaviours (i.e. seeking alternative employment, etc.).
	Burnout	Burnout is an individual experience that is specific to the work context. It is a prolonged response to chronic emotional and interpersonal stressors on the job and is defined by the three dimensions (e.g. emotional exhaustion, frustration and withdrawal).
	Stress	Psychological symptoms of stress refer to the individual experience that is often related to the work context. Symptoms are often a result of perceived chronic demands exceeding perceived ability to cope often resulting in feelings of tiredness, being worn out, nervous, tense and on edge.

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Violence and aggression management training for trainers and managers

A national evaluation of the training provision in healthcare settings

Part 2: Practioner Report

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This report, in the form of a tool-pack, has been developed as result of the research carried out by the Institute of Work, Health and Organisations (I-WHO), University of Nottingham. This research was commissioned to evaluate the effectiveness of violence management training within Healthcare settings across the UK. The outcomes of this research were two-fold: 1) to produce a research report on the impact and effectiveness of violence management training across the Healthcare sector and 2) to produce a tool-pack which can support and improve the provision of training in this area. This report is the tool-pack and has been written by the authors to provide support and guidance to those with a responsibility or interest in designing, delivering or managing violence management training within Healthcare settings. The companion research report which documents the findings from the research is provided in Part 1.

This report and the work it describes were funded by the Health and Safety Executive (HSE). Its contents, including any opinions and/or conclusions expressed, are those of the authors alone and do not necessarily reflect HSE policy.

HSE BOOKS

ACKNOWLEDGEMENTS

We would like to thank the Health and Safety Executive for funding this research. Particular thanks go to Josephine Gravell for her continued support and guidance throughout the project. We are also very grateful to Judith Reilly for help and useful comments throughout the write up process. We also extend our thanks to all members of the Steering Group and thank them for their input and guidance throughout this research.

We also extend our gratitude to all the individuals who assisted and collaborated with us during the earlier and qualitative stages of the research.

We are extremely grateful to all those participating organisations that have helped us in our research and extend this thanks to all the individuals who completed the questionnaires. Particular thanks are also extended to those Trusts who have helped to develop the case studies for this report.

We finally would like to thank Angeli Santos for all her help and support and Marissa Gousti for all her input.

ABOUT THE INSTITUTE OF WORK, HEALTH AND ORGANISATIONS

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- A quality provider of postgraduate education and training in vocational areas of applied psychology and related subjects.
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The Institute attempts to manage a healthy balance between its commitment to and investment in research, and related activities, and its ability to provide quality postgraduate education and training.

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EXECUTIVE SUMMARY

This document has been written to act as an introductory and practical guide to support strategic thinking and improved decision making with regards to training in violence management within Healthcare settings. There is a large investment afforded to violence management training and it is therefore necessary that those who have a direct responsibility for overseeing and/or delivering training services are equipped with tools to assist them in continuously improving the training they design and deliver. A companion research report, from which this practitioner report has evolved, documents the key findings from the national evaluation research programme and can be obtained from the HSE website.

The information contained within this tool-pack is structured around the well-defined training cycle. The key principle behind the training cycle is that it provides a structure and system against which efforts to introduce training should be considered. It specifies at least four important components (from conducting a training needs analysis, to principles of training design and delivery through to the evaluation of training) around which performance should be coordinated. The tools have therefore been written to foster discussion and enable strategic thinking, planning and decision making to occur around each of these components of the training cycle.

This report is structured in four parts:

- Part one provides a general introduction to the report covering its aims and objectives
- Part two provides a summary introduction to each area of the training cycle before presenting some tools and techniques for carrying out that particular activity
- Part three, includes five case studies from organisations within the Healthcare sector who have initiated action with regards to violence management training
- Part four includes a monitoring tool for those responsible for assessing the provision of violence management training.

This report can be used in many different ways and has been developed so that sections can be accessed and read independently or sequentially depending upon specific circumstances or requirements. It is intended that the tools empower and inform both those involved in the design, delivery and commissioning of violence management training, as well as those involved in the evaluation, inspection and regulation of such training.

1. PART ONE: INTRODUCTION

1.1 TRAINING IN VIOLENCE MANAGEMENT

This tool-pack has been developed as result of the research carried out by the Institute of Work, Health and Organisations (I-WHO), University of Nottingham. This research was commissioned to evaluate the effectiveness of violence management training within Healthcare settings. The outcomes of this research were two-fold: 1) to produce a research report on the impact and effectiveness of violence management training across the Healthcare sector and 2) to produce a tool-pack which can support and improve the provision of training in this area.

This report is the tool-pack and has been written to provide support and guidance to those with a responsibility or interest in designing, delivering or managing violence management training within Healthcare settings. The research report which documents the key findings from the research can be obtained from the HSE website.

1.2 THE GOAL OF THIS WORKBOOK

The goal of this tool-pack is to provide a common framework (i.e. method and process) against which staff training needs in relation to violence management training can be identified, training programmes designed and assessments of the effectiveness of such training completed. There is a large investment afforded to this type of training and it is therefore necessary that those who have a direct responsibility for overseeing and/or delivering training services are equipped with tools to assist them in continuously improving the training they design and deliver.

The key principle behind this tool-pack is to the support the development and capability of those (front line) employees who unfortunately have to face work-related violence and aggression. The term capability refers to staff member's perceived ability, confidence and self-assurance that they have the necessary knowledge, skills and understanding to be able to deal and cope with the violent/conflict situations that they might face in relation to the work environment. This tool-pack aims to enhance staff capability through the provision of tools (i.e. information, advice, guidance, checklist, techniques and case studies) designed to improve all aspects of training practice.

The information contained within this tool-pack is structured around the well-defined training cycle (see Figure 1). The training cycle should in itself be considered a tool to support and assess current training practices and procedures. For example, and in line with the training cycle, it is recommended that before training is introduced some form of needs assessment (i.e. problem identification) is conducted. It is only from a comprehensive understanding of training needs (organisational and individual) that the objectives and learning outcomes of training can be determined and instruction designed and delivered in a way that meets such needs.

Although training has an important part to play in the development of individual capability (i.e. knowledge, skills, etc.), how capable one feels about dealing with workplace violence and aggression is also a direct reflection of one's belief, trust and confidence in the organisational systems and procedures in place to protect and support staff. Capability, in other words, is not simply a matter of an individual's perceived ability to 'cope'. It also embodies employees' perceptions of the organisation's ability to cope. This translates into judgements of the support, professionalism and competence that one feels there is in one's immediate work group and in the organisation more generally. This latter sense of organisational capability manifests itself in such

indicators as the perceived value and utility of incident reporting systems, the strength and integrity of the organisation's policy on workplace violence, as judged by its staff, and the visible demonstration that any organisational action taken to tackle violence actually works. In this context, training in violence management should not be seen as the panacea to this workplace hazard but instead viewed as just one important strategy for tackling, managing and preventing work-related violence and aggression.

Figure 1: Showing the training cycle around which this tool-pack is structured

1.3 WHAT DO WE MEAN BY A TOOL?

This document has been written to act as an introductory and practical guide to support thinking and decision making with regards to training in violence management within Healthcare settings. There are many different views of what is and what is not a tool; the tools included in this document have been developed to support problem solving within any circumstance associated with instructional learning and development. This tool-pack does not, for example, include an instrument (e.g. a comprehensive questionnaire) that can be used to gather information under all circumstances. However, the tools have been written to foster discussion and enable strategic thinking, planning and decision making with regards to violence management training.

1.4 CASE STUDIES

Case studies have also been included within this tool-pack. The case studies serve to demonstrate how the various parts of the training cycle fit together. The case studies should also be regarded as a tool as they provide first hand experiences of actions taken by organisations within the Healthcare setting to improve their training efforts. The case studies have been developed to

reflect organisational realities with an aim of supporting organisational as well as individual learning and development.

1.5 HOW TO USE THIS TOOL-PACK

This tool-pack has been designed with two purposes in mind, 1) to provide the reader with sound background knowledge to the key areas of the training cycle (see Figure 1) and 2) to provide some tools and techniques to assist in the design and delivery of effective training.

This report is divided into three remaining parts:

- Part two provides a summary introduction to each area of the training cycle before presenting some tools and techniques for carrying out that particular activity
- Part three, includes five case studies from organisations within the Healthcare sector who have initiated action with regards to violence management training
- Part four includes a monitoring tool for those responsible for assessing the provision of violence management training.

From the HSE inspector's point of view, this tool can be used to inform discussions with the appropriate representatives from the organisation being inspected.

This workbook can be used in many different ways and has been developed so that sections can be accessed and read independently or sequentially depending upon specific circumstances or requirements.

2. PART TWO: TRAINING CYCLE AND TOOLS

2.1 INTRODUCTION TO THE TRAINING CYCLE AND TOOLS

Figure 2 shows the main inputs and outputs for each of the aforementioned training cycle components. Figure 2 also serves to demonstrate that the content (i.e. 'the what') and the process (i.e. 'the how') of evaluation should be considered continuously throughout the project lifecycle. In addition, the training project should be overseen by either the training function or a project group convened to examine a particular organisational or training issue.

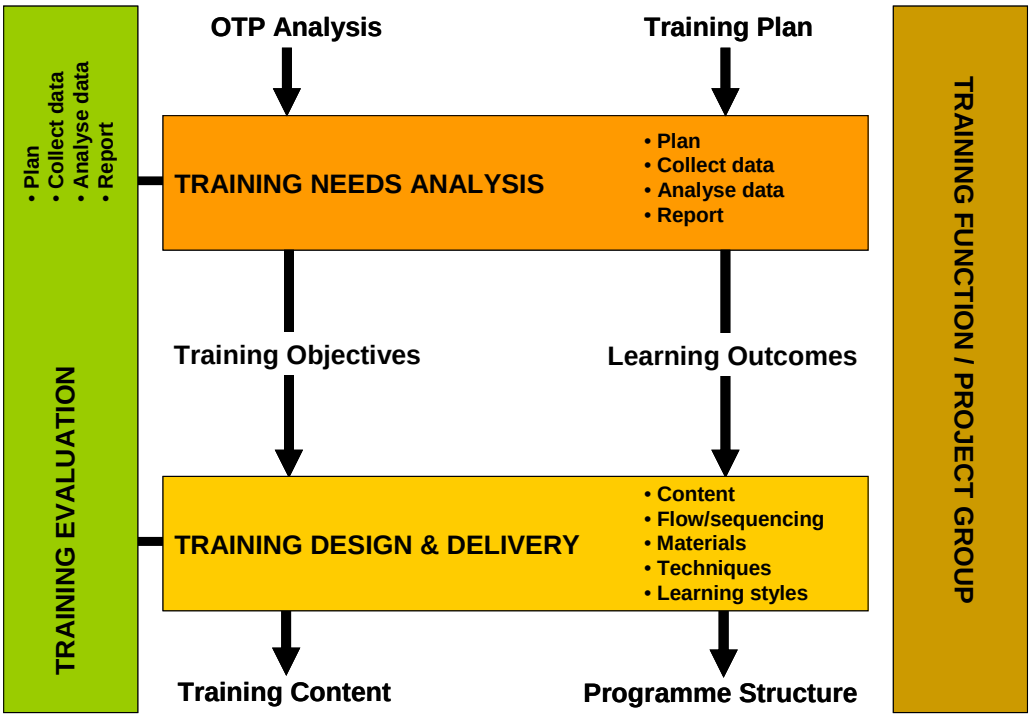


Figure 2: Outlining the content structure of the workbook against the training cycle

The tools that follow should be considered as the starting point of a more strategic and planned approach to the design, delivery and evaluation of training. These tools will support the efforts to enhance training efforts but they should not be considered as an exhaustive list of the tools available. There are numerous techniques and strategies to support the successful completion of the actions surrounding the training cycle but to include or review each of these techniques extends beyond the scope of this report.

3. TRAINING NEEDS ANALYSIS (TNA)

3.1 INTRODUCTION

The aim of a Training Needs Analysis (TNA) is to assesses and better meet the competency requirements of the organisation and the persons who operate within it. A TNA is a structured approach to identifying the training which is required in an organisation so that strategic (*corporate, team or individual*) objectives can be achieved. The TNA, to be most effective, should identify what staff need to know as part of their job, what they need to be able to do better and what they need to be able to do differently.

The outcomes of a TNA should be used to establish both the objectives of the training (i.e. what the training aims to do and how this relates to the organisations objectives) and the specific learning outcomes (i.e. what the trainer will teach the participants). It should be against these objectives and outcomes that the training efforts should be evaluated.

An effective training needs analysis will assist by helping to identify training issues and priorities in a systematic way and not on an ad hoc basis. By examining individual as well as organisational needs, more effective decisions can be made with regards to the participants of training, content of training, the delivery methods and other factors which serve to improve the overall quality of the training effort.

3.2 THE NEED

To support the overall aim of improving the performance and the knowledge, skill and ability of employees a review of training needs must be undertaken. Typically, the need to conduct a comprehensive TNA arises when:

- new people are selected into the organisation or people change jobs;
- new working methods are introduced (including new technology);
- new initiatives are implemented; and
- higher standards of achievement or performance are required.

Each of these situations will mean that people have to undertake different tasks, actions or behaviours, or they have to do the same tasks, actions or behaviours in different ways. The gap between what is required and what currently takes place can be seen as the ‘need’. Unless this need is met by other methods, such as recruitment, or restructuring the work, then people are likely to need help to learn new knowledge, skills and abilities (i.e. through training and other systems of support).

3.3 BENEFITS OF THE TNA

The information obtained from a TNA can be applied in many ways and can help to inform and support various functions throughout the organisation or work group by, for example:

- Establishing the content of training;
- Establishing the objectives of training;
- Establishing the learning outcomes of training;
- Establishing whether, indeed, particular forms of training are required;

- Informing the evaluation of training that is developed, chosen and delivered; and
- Supporting performance appraisal and management processes associated with the development of employees (i.e. through the use of competency frameworks).

3.4 IT'S NOT JUST ABOUT TRAINING

It is important to recognise that there are numerous factors which may influence the outcome of a project. To this end, it must be reiterated that, training must not be seen as the panacea for improving performance deficiencies but as one element to support this process.

3.5 TOOLS FOR ASSESSING TRAINING NEEDS

As shown in Figure 3, the inputs (i.e. the information that supports the TNA) of a needs analysis can come from a variety of sources. Often organisations have conducted some form of analysis at the Organisation, Team or Person (OTP) levels. This information may be immediately available in terms of corporate objectives, policy documentation or other more focused technical documents that have been written as part of a specific project to assess a particular organisational issue (i.e. risk assessments for violence and aggression) or training need. It is vitally important that such sources of information are reviewed and considered in any attempt to assess the training needs of staff with regards to violence management. A training plan is also an important input for any training needs analysis (*and evaluation*). The training plan should include, for example, a description of the course, who is to be trained, as well as other information associated with the content and outcomes of the training. It is often more reliable and more valid (*accurate*) to obtain information from multiple sources, in this way findings can be compared to determine the level of agreement or disagreement between the results obtained and the potential stakeholders. The outputs of a TNA should be a clear set of training objectives (i.e. what the training will deliver for the organisation) as well as well specified learning outcomes (i.e. what specific knowledge or skill components the trainees will learn).

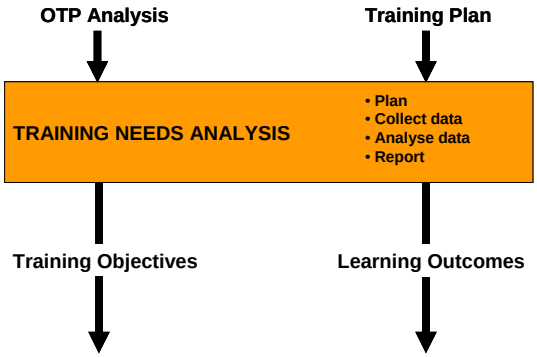


Figure3: To show the inputs and outputs of a TNA

The purpose of the tools that follow is to bring about a greater degree of reflection upon the design and delivery of violence management training. A critical weakness in ineffective training – as detailed in the research report – was its failure to meet their training needs, as seen by staff members themselves. This finding bore out the earlier conclusion of the NAO report (2003)[1] that there was often only a very poor alignment between what violence management courses offered, in terms of content, and what delegates and organisations actually needed. The value of a thorough training needs analysis is that it helps guarantee alignment between training content and individual and organisational requirements.

3.6 TRAINING NEEDS ANALYSIS TOOL 1: PLANNING A TNA

To support the successful implementation of training a simple process is outlined below which, when followed, should enable the systematic, organised and planned collection of evidence to allow for the design of instruction which is fit for purpose. The outcome of conducting a TNA should be a TNA Report. The report should then be used to support numerous activities associated with the design, delivery and evaluation of training.

The process of conducting a 'training needs assessment' can be thought about in four main phases: 1) planning, 2) collecting data, 3) analysing data and 4) preparing the final report.

Phase 1: Planning

An effective needs assessment focuses on one job classification or stakeholder group. Once the audience (or stakeholder group) is identified then a strategy is developed for collecting the data/information. The planning stage of the needs assessment should also comprise asking and answering questions such as:

1. Who will manage the needs assessment process?
2. What is the purpose of the needs assessment?
3. What are the key questions the needs assessment must answer?
4. Who will participate in the needs assessment?
5. Will responses/information be gathered from a sample of the target audience or is there enough time and resource to question everyone?
6. How will the information be collected?
7. Who else will it be important to include in the process because of their ability to influence the outcomes of the instruction (i.e. supervisors and/or managers, etc.)?
8. How will the information collected be analysed?
9. How will the needs analysis be reported?

The planning phase is about mapping out the entire needs assessment process from start to finish.

Phase 2: Collecting the data

The collection of data rests upon some key decisions being made early on in the planning process. Consideration needs to be given to:

1. What methods will be used to collect data (e.g. Interviews, Questionnaires, Focus Groups)?
2. Who will form the participants of the needs assessment process (i.e. will the needs assessment include all members of staff or is it only practical to obtain the views from sample of staff)? If sampling does occur then this must be representative to limit any biases in your efforts to understand the training needs. Interviewing people from just one area is likely to provide a false picture, unless of course these people are the target audience for the instruction.

Phase 3: Analysing the data

Once collected, the data must be analysed in a way that enables a prioritisation of needs. These can be prioritised on the basis of, for example:

- Economic value (i.e. cost to the organisation);
- Impact (i.e. number of people affected);
- Frequency of occurrence (i.e. if a particular type of conflict/violence recurs);
- Timeliness (i.e. is a need identified which will assist organisational objectives as well as wider policy changes in the sector);
- Difficulty (i.e. are certain needs too difficult to be met by training alone); and
- Complexity (i.e. are certain needs too complex to be met by training alone).

Phase 4: Compiling a final TNA report

The following headings can be used to support the structure of a report, which details the outcomes of the needs analysis:

1. Summary of the purpose (i.e. what was the main objective of the TNA and what questions did it set out to answer?);
2. Summary of the process (i.e. how it was done who was involved?);
3. Summary of the results (i.e. what specific knowledge and/or skill based requirements were identified?); and
4. Necessary recommendations based on the data:
   - The objectives of the training programme;
   - The relationship between the programme objectives and the objectives of the organisation;
   - Possible learning outcomes of the programme; and
   - An outline description of the course content.

3.7 TRAINING NEEDS ANALYSIS TOOL 2: TNA CHECKLIST

This checklist should be consulted when conducting a training needs analysis. The checklist can be used to complement techniques such as questionnaires, interviews or focus groups. Together the information gathered throughout the needs assessment process should be used to feed into the design and selection of training, the delivery of training as well as the evaluation of training.

1. **Who is training for?**
    a. Is the training for all staff?
    b. Is the training for a specific group (i.e. *team/department*) of staff?
    c. Is the training for a specific role (i.e. *nurse*/*manager*) within the organisation?

2. **At what level are needs being assessed?**
    a. Have the needs of organisation been considered?
    b. Have the needs of particular departments or teams been considered?

3. **How will the needs of staff be identified?**
    a. Has a risk assessment been conducted that can support the identification of training needs?
    b. Are you able to gather information about training needs using other qualitative and quantitative methods of data gathering such as focus groups with key personnel, interviews or surveys?

4. **Are you able to make use of other forms of knowledge and information to support the needs identification process?**
    a. Can information be obtained from incident report forms?
    b. Can information be obtained about when, where and how staff members are exposed to incidents of violence?
    c. Is information regarding the job role (i.e. job descriptions) readily available?

5. **Are you able to make a case for why a particular method or content of training is needed?**
    a. Is there a specific knowledge requirement?
    b. Is there a skill requirement?
    c. Is there an ability requirement?

6. **Are you able to prioritise the needs of the individuals concerned?**
    a. Is there a requirement for specific knowledge or skills?
    b. Is training required for all staff?
    c. Are some groups in greater need of training than others?

4. TRAINING DESIGN AND DELIVERY

4.1 INTRODUCTION

Staff training and development is an investment and it is therefore important that such an investment is approached in a systematic manner. Therefore decisions about, for example, the selection, design or delivery of any type of training intervention should not be made without well written objectives and learning outcomes e.g. what is the purpose of this training, how does this relate to organisational objectives? and what will this training achieve? As shown in Figure 4, the specification of training objectives will enable decisions to be made with regards to the content of training, issues associated with the sequencing of the training material and how such material should be delivered (i.e. teaching methods). It is also important to remember and to recognise that the objectives and learning outcomes of any training programme should be the starting point of any effort to evaluate the training.

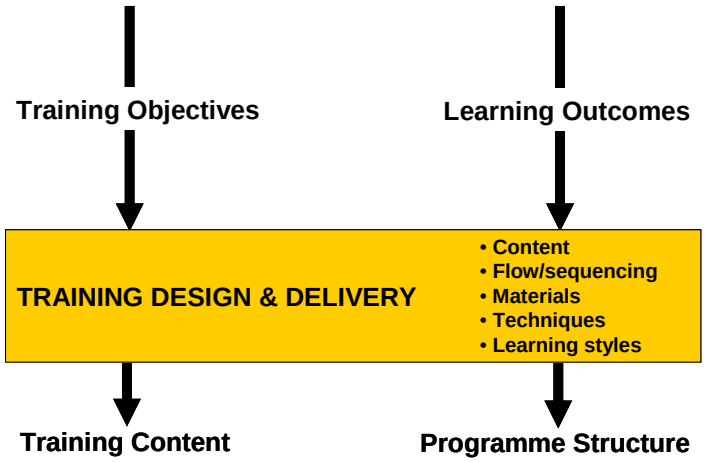


Figure 4: The inputs and outputs of the design and delivery of training

4.2 TAKING THE TIME TO THINK ABOUT DESIGN AND DELIVERY

There is often a misguided belief that once the content of training has been identified, the translation (or delivery) of this information to the trainee is as a straightforward and as simple as giving a 'patient a pill to swallow'[2]. Even though quick and easy solutions (e.g. off the shelf packages) seem to cater for the needs of the individual learner, it is important to think about the wider aspects associated with the design of effective instruction. What the decision maker (or training designer) must also respect are the differences and limitations between individuals in terms of the way in which information is attended to, processed, understood, retained, recalled and used, as well as differences in motivation and other issues associated with their attitude towards instruction and learning. How information is structured, documented and delivered/presented is extremely important for the quality of learning and degree of transfer that can occur.

There are many different models, theories and books written about effective training design. However, the key issues for any instructional designer to consider are highlighted in Figure 5.

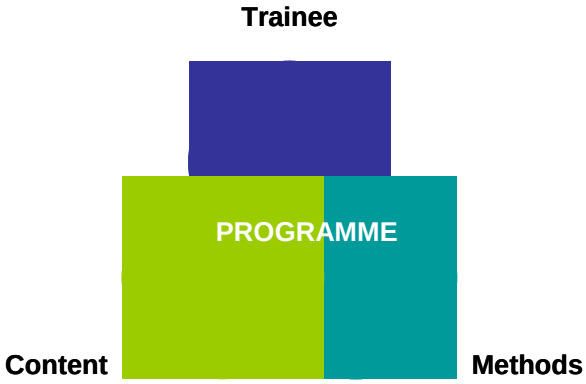


Figure 5: Key components of training design

It is important to recognise that each of the individual components will influence both the effectiveness of any programme of instruction as well as the extent of training transfer to the work setting. As outlined above, the content of training must necessarily evolve from some form of analysis of need. The content must be structured and sequenced in some logical fashion so that the knowledge and or skills can be learned in manageable parts. It is also important that the designer of the instruction considers the various methods and strategies by which the content of training can be delivered and translated to inform, develop and assist learning. There are various methods of delivery, a review of which extend beyond the scope of this tool-pack. However, it is important that trainers and those who design training consider how best to foster learning through the consideration of the timing (i.e. before, during and after) of the delivery of the training material as well as the process (i.e. the medium) by which this material is delivered. It may be that on some occasions, providing the trainee with a workbook to complete before, during and after training is an effective means of instruction. On other occasions, a more interactive and participative approach to the training might be warranted with the trainer adopting more of a facilitative role, thereby assisting delegate problem solving in a more dynamic and fluid manner. Finally, it is important to recognise the impact of individual differences between trainees with respect to, for example, their experiences and backgrounds, their own knowledge and skills, as well as their attitudes and motivations towards the instruction. These factors will no doubt influence the knowledge and skills of what has to be trained but will also play a part in how information communicated during training is understood, assimilated and used.

4.3 TOOLS FOR DESIGNING AND DELIVERING TRAINING

Designing or selecting training that is effective (i.e. accomplishes specific objectives relevant to participants needs) is not a simple endeavour. This tool-pack is unable to provide the reader with a full overview of the issues to consider and how to overcome these issues; however the tools included do provide the decision maker with key questions that should be considered and/or answered before and during the design or selection of any training.

Ultimately, the design of any training will need to focus on four key areas:

- The trainee (i.e. what are the characteristics of learners or trainees?);
- Outcomes and objectives (i.e. what is expected of the trainees at the end of training?);
- Programme structure and delivery (i.e. how the subject or content is best learned and what methods of delivery or instructional strategies are to be used?); and
- Evaluation (i.e. how will the programme be evaluated and the effectiveness of the learning be demonstrated?).

4.4 TRAINING DESIGN AND DELIVERY TOOL 1: DESIGN & DELIVERY CHECKLIST

This tool comes in the form of a list of questions. These questions can be adapted and asked of those who are providing (selecting, delivering or selling) training or can be considered by those (e.g. teams or individual persons) who have a specific role to design a programme of training.

Objectives of training

- Does the training have clear and specific objectives (i.e. is the relationship between the training objectives and the application of those objectives made clear and explicit)?
- Do the training goals and objectives clearly relate the training to the desired performance back on the job?
- Are the objectives realistic?
- Are the objectives in line with standards set out by other authorities and agencies (e.g. Health and Safety Executive (HSE) and Security Management Service (SMS))?
- Are the objectives in line with guidance set out by other relevant bodies or groups (e.g. National Institute of Clinical Excellence (NICE), National Institute for Mental Health In England (NIMHE), Welsh Assembly, Scottish Executive, etc.)?

Key topics of training

- How does all of the content support the objectives?
- How accurate and up to date is the content of the training?
- Is the level of content appropriate for the learners?
- How does the content of the training programme align itself with standards and guidance published by agencies and bodies such as the HSE and SMS?
- How does the content of the training programme align itself with standards and guidance published by other relevant bodies or groups such as NICE, NIMHE, etc.?
- Does the training provide an appropriate balance between the topics emphasised and the perceived needs of staff (see *'Training evaluation tool 2: content validation questionnaire'* section 5.6 of this report)?
- Does the training emphasise and demonstrate the organisational context, by including content on, for example:
    - Reporting procedures;
    - How reporting information is used in terms of taking action;
    - Organisational, team and individual support practices and procedures; and
    - How the organisation is progressing and learning.

Training Flow

- Is there sufficient variety in learning activities and training methods?
- Do methods included in the design support the training goals and objectives?
- Does the sequencing of material and topics seem reasonable (i.e. with most elements leading clearly to the ones that follow)?
- Are a variety of learning styles engaged and satisfied by combining methods?
- Are the time estimates reasonable (i.e. will the time allocated for the training allow for the topics to be covered in enough breadth and/or depth to meet the learning needs of the delegate)?

- How is the training sensitive to the training characteristics of the adult learner in general (i.e. are learning styles and preferences taken into consideration through the use of various instructional strategies)?
- How will the training focus on application (i.e. are there clear links and strategies to support the end goal (transfer) of training)?
- Has the training considered the diverse needs of the learners (i.e. has the design of the training taken into account differences in personal experience related to factors such as gender, race, ethnicity, religious background, age, physical and mental abilities, etc.)?

Materials

- How do utilised materials support the objectives?
- Are the materials supplied appropriate for the intended learners and easy to use?
- Is there a stated purpose for each learning activity?
- Do any audiovisual materials fit the objectives and the learners?
- Are the audio visual materials realistic for the conditions under which the training will be delivered?

Evaluation

- Is there a plan for the evaluation of training?
- What are the questions the evaluation is trying to answer?
- Will the evaluation enable the objectives and outcomes of the training to be assessed?
- What methods are being used to collect evaluation data?
- Are there opportunities during the training for participants and instructors to assess progress towards objectives?
- Are there tools that measure the behavioural outcomes of the training?

4.5 TRAINING DESIGN AND DELIVERY TOOL 2: DELIVERY OF PHYSICAL SKILLS

The ubiquitous presence of physical skills tuition for violence management training within the Healthcare sector has resulted in the development of this tool. The aim of this tool is to highlight and summarise key findings from research on the development of physical skills. Although the questions and statements that follow are a simplification of the issues that need to be considered when developing physical skills, the list highlights the key issues to be considered when designing and delivering physical skills tuition. The list has been developed to act as an *aide memoir* rather than provide a prescriptive set of instructions of how best to teach physical skills. It is important that the design and delivery process of physical skills takes into consideration the specific requirements and constraints of the organisation as well as specific learning needs of the participants.

1. **Describe and provide knowledge of what should be done**
   - Assist in developing an understanding of why, when and how to perform the task/skill

2. **Develop the basic skill (through step-by-step actions)**
   - Demonstrate (i.e. model) the skill in step by step sequences;
   - Provide controlled practice; and
   - Monitor responses and provide feedback.

3. **Develop proficiency**
   - Demonstrate the skill and explain the skill simultaneously;
   - Demonstrate the skill in a logical and sequential order before providing practice;
   - Promote the mental rehearsal of the task to support learning and retention; and
   - Provide all demonstrations from the viewpoint of the performer.

4. **Provide practice with feedback**
   - Provide feedback that enables learners to examine the results of their actions;
   - Correct aspects of performance;
   - Provide de-briefing; and
   - Allow for reflection.

5. **Promote transfer**
   - Provide variability in the practice;
   - Promote overlearning of the skill; and
   - Do not progress to more difficult/complex skills too soon.

6. **Help develop emotional control and capability**
   - Provide information prior to training to manage expectations;
   - Consider the use of relaxation exercises prior to engaging in learning; and
   - Allow for verbalizations of concerns and promote balanced reflections.

5. TRAINING EVALUATION

5.1 INTRODUCTION

The training evaluation process is important to understand. The information provided in this section will support the decision making of trainers, managers and those individuals with a vested interest in assessing and improving the quality of the training service they provide. Put simply, the aim of a training evaluation is to determine whether or not training has accomplished its stated objectives.

However, we must try not to over complicate matters and attempt to utilise complex evaluation designs at the expense of gathering any evidence at all. It is therefore important to recognise that this report will provide information on completing practical and simple evaluations of training rather than engaging in research based evaluations which require specialist technical training.

5.2 THE NEED

The evaluation of training is a necessary but often overlooked element of the training cycle. Evaluation of the effectiveness of training programmes is critical because, without it, organisations have no reliable way of knowing whether training budgets are being spent wisely. In addition, it is important for any organisation to recognise whether the intervention prescribed (i.e. training in violence management) is suitable for the problem that has been diagnosed. There is real value, then, in undertaking training evaluation, not least because only proper scientific evaluation can prove whether or not a training programme:

- Is aimed at important and worthwhile organisational benefits;
- Operates smoothly and effectively and is enjoyed by participants;
- Achieves important skills, knowledge and attitude objectives;
- Uses the best available and most cost-effective designs;
- Is used effectively on the job; and
- Provides valuable and cost-effective organisational benefits.

5.3 WHAT EVALUATION IS AND IS NOT

The evaluation of training should not be seen as simply asking participants to place ticks in a box against a rating scale of some kind or a counting of numbers to help justify the expense of training. Instead, evaluation should be viewed as a systematic process of learning whereby information (both qualitative and quantitative) is gathered at various stages of the training design and delivery process (see Figure 6) to help determine 1) the effectiveness of training, 2) support decision making about current and future training, 3) enable documentation of information of programme improvements and 4) help to determine the overall quality of training provided to staff. If conducted in a routine, systematic and thorough way the information obtained from the evaluation process will help to communicate and demonstrate to senior management the return on their training investment.

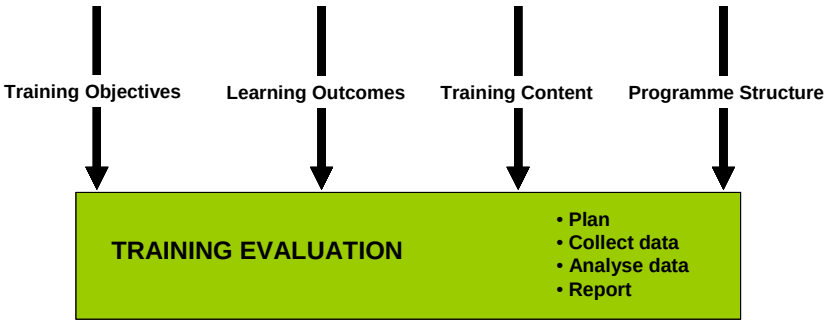


Figure 6: To show the inputs and outputs of the evaluation of training

Figure 6 illustrates that the beginning of the training cycle (i.e. the outcomes of the TNA) should be used as the input for the evaluation. For example, any and every evaluation of training should set out to assess whether or not the objectives and/or learning outcomes of training were achieved. This should be the first but not the only question an evaluation of training sets out to answer. There are of course many other questions associated with the content, design, structure and delivery of training that any evaluation can attempt to answer. In either case it is critical that the evaluation process is structured, planned and carried out in a methodical manner so that information can be gathered in a way that enables the questions of the evaluation to be answered and learning to occur.

5.4 TOOLS FOR EVALUATING TRAINING

There are various guiding models and approaches to the evaluation of training. It is important that when considering the evaluation of any training programme the approach chosen is 'fit for purpose'. Three tools are provided here to support efforts for evaluating the impact and effectiveness of training. The first tool, the evaluation plan, is considered to be the most important for any activity aimed at evaluating training. An outline for planning an evaluation is provided. This outline lists the key topic areas that will need to be included in your plan for the evaluation of training. The questions included in the evaluation plan should be answered by those overseeing and conducting the evaluation. The second tool highlights some key areas of questioning associated with training content and stem directly from the research findings highlighted in the research report. The questions listed can be used to support any ongoing training evaluations. The third tool highlights some of the key design issues associated with isolating and demonstrating the effects of training.

5.5 TRAINING EVALUATION TOOL 1: EVALUATION PLANNING

To support the successful implementation of the evaluation of training, a simple process is outlined below which when followed should enable the systematic, organised and planned collection of evidence to enable the effectiveness of training to be determined. The training evaluation plan is the most important document for the evaluation process. This document should serve as a cornerstone for the evaluation and can be used to communicate to various stakeholders at various stages of the evaluation. The outcome of conducting an evaluation of training should be an Evaluation Report. The evaluation report should then be used to support numerous activities associated with the management of Human Resources within the organisation.

As with the Training Needs Assessment, there are four key phases for conducting a training evaluation these are:

1. **Planning the evaluation** - The plan is the starting point of the evaluation process. The plan sets out the evaluation process and project and acts as a working guide throughout. The plan should also document how the information will be collected, analysed and reported. Key issues to consider here are:

    1. Project management:
        a. Who is managing or overseeing the entire evaluation project?
        b. Who is responsible for the day to day management of the project?
        c. Who are the stakeholders involved in this project?
        d. What are the roles of the various project members?
        e. When does the project start?
        f. When does the project end?
        g. What are some of the key risks and contingency factors?
        h. What is the budget for the evaluation?

    2. What is the main focus of the evaluation (i.e. which course(*s*) is to be evaluated)?

    3. What is the main purpose of the evaluation?
        a. Which course will be evaluated?
        b. What will the course be evaluated against?
        c. What are the reasons for the evaluation?
        d. How will the results of the evaluation be used?

    4. What are the key questions to help demonstrate the effectiveness of the training?
        a. Has the course achieved the specified objectives?
        b. Has the course achieved the specified outcomes?

2. **Collecting information** - Collecting information is concerned with answering what and how will the effectiveness of training be judged. Key issues to consider here are:

    1. What data collection procedures or methods will be used to gather the information required to answer the evaluation questions?
        a. Questions to answer before instruments are designed:
        - How will the data be used?
        - How will the data be analysed?

- Who will use the information?
- What facts are needed?
- Should the instrument be tested?
- Is there a standard instrument?
- Are there any consequences of wrong/biased responses?

3. **Analysing the information** - Analysing the information is fundamentally about how to make sense of the information which is gathered so that it can be used to inform decisions about the training. Key issues to consider here are:

    1. How will the data be analysed?
        a. Use the most appropriate analysis for the data collected;
        b. Do not focus only on the reporting of percentages, consider how to make best use of the data collected;
        c. Review data for consistency & accuracy;
        d. Use all relevant data regardless of positive or negative results;
        e. Treat data confidentially; and
        f. Treat data in accordance with the data protection act.

4. **Reporting the information** - Reporting the information is the final stage of the process and should be used to outline the evaluation process and the key findings. It should act as a report which can be used to inform senior management, trainers, external agencies/bodies as well as delegates who are in attendance at training programmes. Key issues to consider here are:

    1. How will the findings from the evaluation be reported?
        a. Who will take responsibility for writing the evaluation report?
        b. In what form will the evaluation report be presented?
        c. When producing an evaluation report:
            - Understand your audience's needs;
            - Utilise various representations of data (i.e. graphs, figures, etc.);
            - Ensure reports are clear, concise and easy to understand;
            - Make sure information is accurate; and
            - Make sure limitations/biases are listed.
        d. Is there a clear communication strategy for the evaluation report?

5.6 TRAINING EVALUATION TOOL 2: CONTENT VALIDATION QUESTIONNAIRE

This tool lists the core content areas that should be considered when designing and delivering violence management training. The research found that the more balanced a course (i.e. the more it presented a broader organisational context rather than focused on teaching individual skills the more beneficial the training). The items below can be copied into any existing evaluation tool or used as a stand alone tool to assess participant views on the relevance of training programme content both before and after training[1].

CUT AND PASTE FROM HERE

Below are the topic areas that will be covered in this training course. Please indicate how relevant (i.e. useful or practical) you think these topics will be for your own personal work experiences. Please only tick one rating for each topic.

TOPICS COVERED IN THIS COURSE	**Very Relevant**	**Relevant**	**A little relevant**	**Not at all relevant**
Understanding the legal context (including, the right to protect yourself and the use of reasonable force).	☐	☐	☐	☐
Information and models about why and how violence occurs (including, defining violence).	☐	☐	☐	☐
Non-physical management of violence (including, customer care, diffusion/de-escalation, verbal communication skills, non-verbal skills, cultural diversity).	☐	☐	☐	☐
Physical intervention/management skills (including, breakaway and control & restraint techniques).	☐	☐	☐	☐
Organisational policy, procedures and practices in relation to work-related violence (including, roles and responsibilities of management and staff, reporting and emergency action plans).	☐	☐	☐	☐
Post-incident reactions and support (including, how you might feel after an incident, how to get help internally and externally).	☐	☐	☐	☐
[Please enter other topics here]	☐	☐	☐	☐

If 21% or more of respondents rate the content as being 'of little' or 'of no relevance at all' then the entire training programme or the content areas should be reviewed using a second data collection methodology such as a focus group or interview.

[1] This tool can be used to assess participant views regarding the content of training both before and after training. The introductory text for this tool has been written for use before delegates participate in the training programme. The introductory text will need to be edited as follows to allow for the collection of delegate perceptions after training. Replacement text: "Below are the topics that were covered…."

5.7 TRAINING EVALUATION TOOL 3: DESIGNING AN EVALUATION

An important decision to make during the planning of any training evaluation project is associated with how to run the evaluation itself. This tool documents the design issues to consider that will help to isolate the effects of any training programme (i.e. allow you to show that it was training that had an effect and not some other external factor).

5.7.1 Timing of measurements

A critical issue in evaluating any training is the timing of measurements. The evaluation of training can occur at three time points 1) before, 2) during and 3) after. Assessments made before training are used to establish a baseline on whatever is being measured. Measurements taken during training can be used to both assess progress on any measures (e.g. development and performance towards a specific skill or competency objective) and determine any issues to do with the content and delivery methods of training as it unfolds. Assessments taken at the end of training help to document the effects of training and should never be missed.

The following points will support decisions regarding the timing of training:

- Assessments of participants after training should never be missed as these will provide a direct measure of the effect of training.
- If an evaluation is looking to demonstrate learning then assessments should be made both before and after training. For example, if an assessment of knowledge occurs only after training one cannot guarantee that the learning has occurred as a result of the training. This can only be achieved by comparing scores on a test before training with scores on a similar/identical test after training. Any improvement in the scores can be attributed to the training itself.
- If before and after assessments of knowledge are being used, avoid the limitations of using identical tests by designing different test items which assess the same but not identical area of knowledge.
- Regardless of when the assessment is made, ensure that all participants are given a satisfactory explanation as to the purpose of the activity.

5.7.2 Design approaches to isolate the effects of training

Control group designs

An effective strategy for isolating the impact or effectiveness of training is to consider the use of a control/comparison group. A control group is a group of staff who have not recently attended (i.e. in the past 6 months) or are likely to attend (i.e. in the next 3 months) training in this area. The control group participate in the evaluation process (i.e. complete questionnaires at what are 'notionally' the pre-, post- and follow-up time points) but do not participate in (or attend) the training. The scores of the control group on the assessments used are then compared with those of the training group. This design approach is shown below in Figure 7.

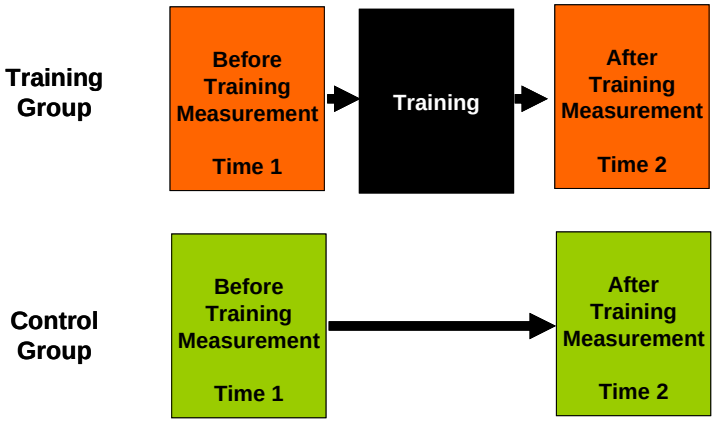


Figure 7: Before and After Training Evaluation Design (*training and control group*)

It is important that at the start of training the scores of the comparison and training group on the measures used to evaluate the training are the same (as shown in Figure 8). If scores between the two groups are not the same at the start of training then one cannot assume the groups are equivalent and therefore any comparisons between the two are limited or futile. In contrast, and at the end of training, it is hoped that the scores of the training and control group do indeed differ (see Figure 8) with the training group score improving over the course of the instruction.

EXAMPLE GRAPH

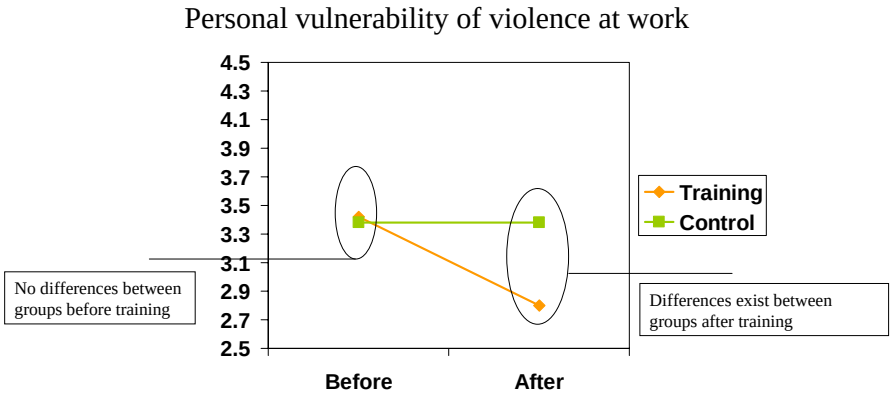


Figure 8: Example of data - before and after evaluation (training vs control group)

Control group concerns

Often questions are raised about the obvious/potential conflict between the health and safety (and rights) of participants and the requirements of the proposed evaluation design (i.e. the denial of training to some staff to allow for the formation a control group). However, the evaluation of training and the use of a control group can be achieved without any risk to the participant. For example, if organisational procedures are such that the target population will form a natural control group (i.e. some staff will not be attending an immediate or forthcoming training programme) then these individuals can potentially form the participants of the control group. If during their participation, as a control group member, an individual requests training and attends before they have completed all control group measures then they should not be restricted or denied training.

Questions are also asked of the participants who can potentially make up a control group. In academic or laboratory settings, where there is a great deal of control over the environment, control group members can be matched with a great deal of precision with training group participants. It is rarely possible to obtain a matched control group in the 'real world'. However, for real world research, obtaining a 'good-enough' control group can be the best option available. A good enough control group comprises other staff for whom violence management training is not necessarily (or regularly) provided (e.g. clerical and office staff). Although some may argue that this is less informative, the design of this research is to provide evidence on training effectiveness.

A multiple measures design without a control group

An alternative approach to gathering data for the evaluation of training is to gather evaluation data (i.e. measurements) at various time points before and after training (as shown in Figure 9).

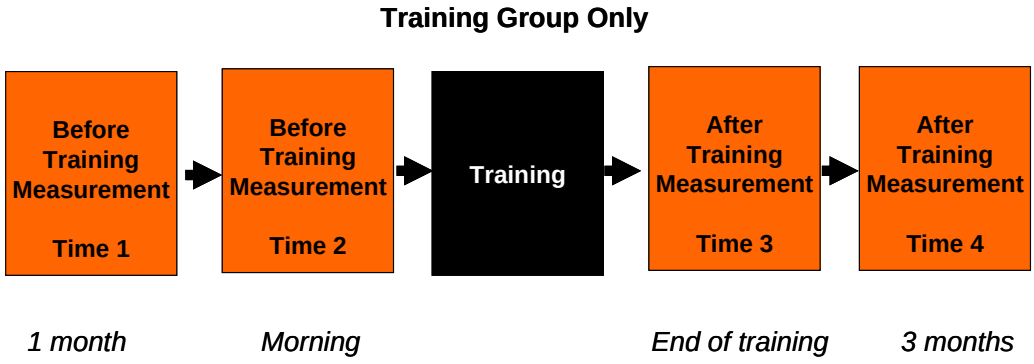
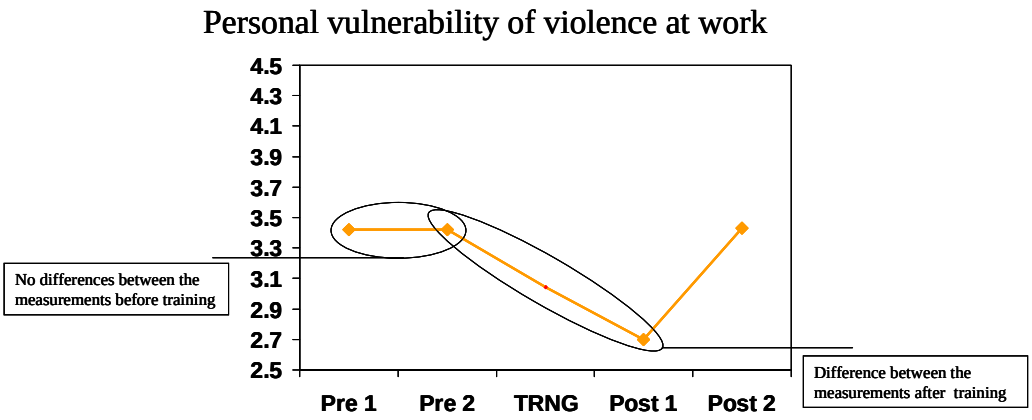


Figure 9: Multiple measures design (*training group only*)

This evaluation design is very powerful and here the training group act as their own control group. That is, measures taken before training establish a baseline against which results after training can be compared. Any differences between the two are attributed to the training (as shown in Figure 10).

EXAMPLE GRAPH



5 point scale: 1: not at all vulnerable 5:completely vulnerable

Figure 10: Example of data – multiple measures design (training group only)

6. PART THREE: CASE STUDIES

6.1 INTRODUCTION

Five case studies are provided to help tell the story of the experiences of some Healthcare organisations. Considering the broader themes of the research from which this tool-pack stems (i.e. support, development and growth), and with a view of transferability, the case studies have been developed in a manner that supports the learning of the intended reader group. Case studies are certainly becoming an essential tool in professional education and it is with this line of thinking in mind that such material has been written. The purpose of using case studies is to present scenarios that are both realistic and informative in that they may assist others in solving their own problems.

To support the development and transfer of competence (e.g. knowledge, skills and abilities), with regards to designing effective instruction in violence management, case studies have been written in a manner that does not just provide answers. Rather, they look to raise questions and allow the reader to reflect on the actions and decisions taken, review the outcomes, and benefit from reading about some of the factors which served as barriers and/or facilitators in these organisational projects. It is imperative that organisations (and individuals within them) are supported in developing their thinking in a way that builds confidence and capability. It is with the purpose of developing capability that these case studies have been written.

It is hoped that, with time, further case studies will be published to key websites (e.g. HSE, SMS, etc.) so that the sharing of experiences might assist in the process of learning and development. For the protection of the Trusts these case studies have been anonymised. The disclosure of the Trust, in any future case studies published to the websites, will be at the discretion of each individual Trust. Should you wish to write and submit a case study then please do not hesitate to contact the authors who have developed a case study tool to assist in this process.

6.2 CASE STUDY ONE: TRAINING NEEDS ASSESSMENT, DESIGN AND EVALUATION

6.2.1 Background

This Mental Health NHS Trust in the South East of England was proactive in identifying a need to establish a specialist post at a senior level to assess the reasons for violence in services and implement a change strategy to improve the safety of service users and staff. A nurse consultant post was established. The 3 main objectives of the post were as follows 1) reduce the incidents of violence and aggression and seclusion; 2) improve staff confidence in dealing with aggression and violence and 3) make 'zero tolerance' a reality.

6.2.2 What was done?

At first the new nurse consultant engaged in a familiarisation process (fact finding mission) to establish the current position in the services. As part of the familiarisation process, the nurse consultant liaised directly with frontline staff from all disciplines and spoke with service users and carers. There was also attendance at service user groups and other relevant departments, for example, Estates, Facilities, Training and Education, Health and Safety, Clinical Governance and other operational managers.

As a direct result of the familiarisation process a more formal action plan was formulated that took into consideration the needs of service users, staff and carers. During the 'fact finding mission' a recurring theme proved to be the need to review the model of training in place with regard to managing violence by introducing a theoretical component with an emphasis on prevention rather than crisis management. Aspects of, for example, risk assessment, prevention planning, de-escalation, service user perspectives, law and ethics, restraint related risks, cultural awareness and post incident review were identified as necessary components. It was acknowledged by all that physical interventions were required but only as a last resort.

A hierarchy of physical interventions was necessary in order to ensure the response to the situation was proportionate and minimised the risk of harm to staff or others and the service user involved.

6.2.3 Project problems

- The evidence base regarding effective outcomes from training in this subject is lacking.
- The change process was hindered by 'opinion based' debates.
- Cost implications were evident as a selection and re-training process was required for the tutors.
- Cost implications are ongoing as the new training model will need to be rolled out across the organisation.

6.2.4 Project solutions

- The work of NIMHE. with regard to the accreditation and regulation of trainers commenced during the change process and the nurse consultant was involved in discussions and

developments.

- The Positive Practice Indicators published in February 2004 reinforced the need for practice change and this aided progress.
- The tragic death of David Bennett and subsequent enquiry and recommendations also reinforced the need to implement the changes proposed with regard to service user safety.
- The tragic death of the Nurse at Springfield Hospital reinforced the need to ensure safe systems for staff.
- The draft guidance from NICE. formally indicated the lack of evidence available but also indicated standards of practice required which were in keeping with proposals for change within the organisation.
- The Nurse Consultant specialising in violence prevention, was involved in work with NIMHE, NICE and the NHS Security Management Service and has implemented systems within the organisation to meet with the objectives of these organisations.
- Support from colleagues, most managers and clinicians, in the Trust throughout the process of change and the appointment of a dedicated risk training manager was extremely valuable in progressing matters. Service user groups and advocacy services also worked hard to support taking forward the change process.
- Importantly, the nurse consultant was motivated to maximise the safety of staff and service users…"*I do not want my colleagues and the people we look after to be hurt and the absolute belief that I could help was the biggest motivator!*"

6.2.5 Outcomes

A comprehensive training programme is now in place. The 5 day 'Control and Restraint Teamwork' course was reviewed and a theory component added covering the themes identified. The physical skills taught were rationalised and interventions based on principles of movement rather than rote learned responses to threat situations were introduced in order to aid recall and retention in a crisis situation. The 'General Services' training model was utilised and Trust tutors were required to attend an instructors course (3 weeks duration) and a selection interview in order to ensure a combination of professionalism, clinical knowledge, teaching ability and values were demonstrated.

Other major outcomes from this project include:

- There is now a process and opportunity to select and educate new tutors.
- Views of service users and frontline staff have been addressed and concerns raised at the 'fact finding' stage now alleviated.
- At present delivery is focused on the in patient services due to the limited number of tutors and suitable training venues. Additional venues have been sought and a further training course for tutors is commencing. Dedicated posts to support the roll out of the training, quality assurance and follow up in clinical practice are in progress.
- The need for a variety of courses to fit service need is recognised and course plans are progressing (e.g. Mental Health Older Adults, Child and Adolescent, Community staff / Lone Workers, Administration and Support Staff e.g. domestics).
- The need to close the training to practice gap was recognised and competency ratings are utilised to inform clinical service managers of participant's strengths and weaknesses and ensure any action, if required, occurs promptly. Participant knowledge is tested using a questionnaire and a workbook and course evaluations are completed which include a confidence rating and questions directed at assessing values.
- Current evaluations indicate a change in culture and thinking and feedback from service users and advocacy services is very positive. A sample of representative comments from

programme evaluation sheets include: “restraint is frightening for patients, it is often not necessary to use restraint, oral medication is better than injections, it is better to talk to people, greater motivation to de-escalate”.

6.2.6 Lessons learned

- The appointment of a motivated lead for the training team is necessary to ensure that ongoing objective evaluation occurs and that programmes are amended to reflect the needs of the participants. Training is only effective if it meets the needs of those attending and subsequently improves staff confidence and the service user experience.
- It was excellent to reflect back and see that the original objective was achieved and positive outcomes were now being realised for individuals and the organisation.
- An important lesson learned was associated with the difficulties that can arise when one focuses on the end goal (i.e. to make the changes happen) without sometimes taking a step back to review the bigger picture. As a result, the process was unstructured and establishing a more formal work plan earlier in the process would have been useful. As a result of the process to recruit new tutors the delivery of training has diminished, fewer courses are being provided and this is causing anxiety for staff. If a more structured approach had occurred this may have been avoided.

6.3 CASE STUDY TWO: MAKING PEOPLE THE PRIORITY

6.3.1 Background

With endorsement from the Executive Board, a strategy for tackling work-related violence within this General Acute NHS Hospital Trust in the UK was implemented. The core objective of the strategy was '*to improve the patient experience by equipping staff with increased levels of personal competencies and enabling them to deal with an increasing diverse patient and public population*'. This strategy was motivated by various drivers including the Government's Modernisation Agenda, NHS Plan 2000, Disability Discrimination Act 1995, Improving Working Lives Standard 2001, Race Relations Act Ammended 1976, Shifting the Balance of Power within the NHS 2001, Essence of Care 2001, Promoting Equality and Diversity in the NHS 2002, Zero Tolerance and the National Syllabus of Conflict Resolution (see SMS) which all focused on the need to design and deliver specific training to enable staff to challenge their behaviour and attitudes and to equip them with skills to deal with situations that may arise within the workplace.

6.3.2 What was done

It was decided that as the whole essence of the strategy was to improve the patient experience this could be done by addressing the attitudes and behaviours of staff through raising awareness around diversity issues, addressing customer service issues and ultimately running Challenging Behaviour workshops to equip staff with de-escaltion techniques should the need arise. Through collaboration with Risk Management, Security and Human Resources and also working with an exteranl organisation, three halfday workshops were developed and introduced as mandatory training for all new starters to the organisation (approx. 140 per month). Initially 6 pilot programmes for diversity awareness were run and an internal 'train the trainer' programme was developed to have a pool of trainers to deliver the session organisation wide. However, because of the nature of the training, a decision was taken to use only training advisors from the training department. These trainers also delivered Customer Care training and have now been trained to deliver the Challenging Behaviour training which provides continuity through the workshops. All the training is delivered on site and booked through a central administration point within the training department. Initially the Challenging Behaviour workshops were delivered only by our Security Manager which proved a problem because of time restrictions. New staff have 3 months in which to complete this training and current members of staff are also invited to attend. The Trust also developed a video, using staff members and actual case studies of real scenarios. The video is shown to all new staff at corporate induction and forms an integral part of the annual refresher training. Additonal Breakaway and Control and Restraint training is also available for staff from high risk areas and specific staff groups.

6.3.3 Project problems

- Resources - financial to employ adequate trainers to deliver programmes.
- Lack of training rooms on site.
- Necessity of qualified trainers to first attend the Challenging Behaviour information session in Coventry before being able to deliver the training.
- Releasing of staff by departments to attend the mandatory training.
- Buy in from Clinicians/Medical Directorate to enforce attendance.
- Time restrictions on trainers.

6.3.4 Project solutions

- Crucial to have endorsement of Corporate Functions Group (Executive Board) to make the training mandatory.
- Dedicated Aminsistration support.
- Conducted 6 month evaluation looking at attendance (i.e. numbers, staff groups, departments, etc.) as well as impact of training on individuals and departments.
- Constant updating of programme in view of feedback.

6.3.5 Outcomes

From the results of the evaluations and ongoing discussion between the trainers who deliver the sessions, various changes are underway to improve the training content and also to make sure that it is being delivered to all new starters. Currently the mandatory training requirements of the organisation and a training matrix is being designed to make it easier for managers to understand. It is hoped that this will influence positively the numbers of attendees. Action is currently being taken to integrate and include variants of the Challenging Behaviour training into orientation programmes for other staff groups (e.g. Clinical Support Staff, Qualified Nurses and Clinicians).

6.3.6 Lessons learned

- There was much to be gained in terms of working in partnership with risk management and security.
- A great deal was learned about the design and development of training programmes.
- A lot was learned about the benefits and positive outcomes of continuous evaluations of training.
- Some difficulty was experienced in terms of obtaining buy in from Clinicians.
- Some difficulty was also experienced in terms of course attendance, where mandatory training actually means mandatory!

6.4 CASE STUDY THREE: CONTROL & RESTRAINT TO SAFE HOLDING

6.4.1 Background

The case study involves the change in training courses from Control & Restraint to Safe Holding using a new model of training within a Mental Health NHS Trust in the UK. It identifies the reasons underpinning the need to shift the emphasis of training from one focused on systems to one that is principles based and enabling staff to manage aggression better. It was recognised that the National focus is shifting towards a more therapeutic model with the removal of pain-compliance. A training model was also required that allowed for greater transparency in the event of complaints from service users and staff. Another very important consideration was the need for better support for trainers from training providers. Finally, a key objective was to be able to support staff in the clinical environment so that training wasn't just a 'once a year event'.

6.4.2 What was done

A training needs analysis was completed to establish what was required, for example, removing pain-compliance in line with current opinion, providing on-going support for staff, the need for support for trainers, levels of ability/fitness of staff and a need for a more patient-centred approach. This analysis also looked for a training model that could be applied to all staff in the Trust, regardless of the client group they worked with.

Open discussions were held between trainers in 2002/3 at a trainers meeting led by a facilitator. The facilitator met with a potential training provider at a conference and started a dialogue with them to look at the match between their training, both for trainers and practically within clinical settings, and the specific needs of the Trust.

Once the decision to switch had been made, two trainers were sent on the train the trainer (instructor) programme. Following this, a process was initiated to support the introduction and integration of the new skills (and principles) into the current training provision. The key interim objective was to provide some alternatives to pain-compliance techniques and to commence the move to a more therapeutic course.

The changes were then evaluated and reviewed, and with most trainers being happy with the changes, arrangements were then made to convert and up-skill existing trainers to the new model. A decision was then taken to remove support for pain-compliance techniques by September 2004.

6.4.3 Project problems

- Resistance from staff to remove pain-compliance as they had used this for a long time and were worried that the new skills would be of no use and they were in danger of being hurt.
- Resistance to change by trainers who were comfortable with teaching existing skills and also were sceptical about the efficacy of the new model.
- Getting the message out about the changes to training and the potential implications for practice.
- The Trust were very supportive of the changes at directorate level and the finances were made available to train and update trainers.
- A permanent team of trainers was established following a Health and Safety Action plan and this enabled concentration on the rolling programme of change without the distraction of having to spend the majority of time in clinical practice.

6.4.4 Outcomes

Health & Safety action groups were utilised to inform staff of the changes. The change to the new model has by and large been widely accepted by staff in the Trust and the trainers, though there have been pockets of resistance in both groups. Overall, staff feedback has been very positive to the changes, most feel that the principles based approach of the new model provides them with much more flexibility to deal with aggressive situations than the old systems-based training which did not incorporate a level of 'what if.'

There is now much more emphasis on the theory behind violence and aggression. One key objective of the training is to provide service-users with more control, choice and responsibility in the decision making process before restraint is initiated. If an incident does occur the service-user is again given a greater degree of control, choice and responsibility so that aggressive situations can be more quickly and safely de-escalated.

The training team have started to build on staff support issues and now regularly visit clinical areas to assess patients and offer advice on dealing with particular incidents and how to adapt the system to individual situations. The team have also become involved in wider National initiatives (e.g. NICE, NIMHE and the SMS) to help influence and support future practice.

6.4.5 Lessons learned

- Looking back the approach to the change would have been handled slightly differently. It might have proved more advantageous to promote and communicate the impending changes across the clinical areas first (i.e. by using ‘roadshows’ and other means of communication). This may have helped overcome resistance to the removal of pain-compliance by some members of staff in more high-risk and potentially more challenging areas.
- It might have also been useful to communicate the change plan to the Senior Management Team (SMT); as the experience of the SMT could have supported the strategy for communicating and implementing the changes, facilitated take up and reduced some of the resistance. For example, the new training has caused problems with one directorate who have decided to retain their existing training, rather than adopting the new model which has been rolled out Trust wide.

6.5 CASE STUDY FOUR: MERGING OF TRAINING BETWEEN TWO TRUSTS

6.5.1 Background

This was a unique situation in that it involved a merging of the training efforts between two neighbouring Mental Health Trusts in Wales. The need to merge arose from the fact that both Trusts experienced problems with staff attendance at their courses. The small numbers attending training represented a risk towards the viability and continuation of the programmes on offer to staff. Informally representatives of both Trusts started to talk to each other about their issues and regularly offered mutual support and problem solving advice over the telephone. Very quickly it became apparent that combining training efforts would assist in overcoming issues associated with classroom numbers but would also mean that other benefits could be realised.

6.5.2 What was done

The first stage in this process was dependent upon agreement being achieved about whether or not a potential merging of the training functions was a viable way forward. Agreement was achieved through a careful analysis of the costs and benefits of the merge. It was established that the benefits of merging the training services outweighed the problems (*costs*) and a decision was taken to develop a business case of the proposed merge and present this to representatives of senior management from both respective Trusts. The business case set out the strategy for action, outlining the costs, logistical issues but very importantly the benefits (both tangible and intangible) of the suggested move. Some of the benefits included developing a more diverse and technical skill mix, building a stronger team, improving morale, job satisfaction, improving the range of courses on offer, a better student-teacher ratio, reduced risks in the development and delivery of physical skills instruction, sharing knowledge, experiences and skills that could feed directly into the design and delivery of training.

6.5.3 Outcomes

The main outcome of this process was the merging of two training functions from two Trusts under one unit within one Trust. Trainers are still employed by their representative Trusts but are now are able to offer their staff a great variety of training more aligned to their specific needs.

A further outcome of the merger is one which has enabled the training function to be more integrated and involved with strategic discussions and decisions, both internally and externally, regarding violence management as well as health and safety management in general.

The process of merging two training functions has also supported and enhanced the personal development and confidence of the trainers. Under the previous structure, trainers often operated alone and therefore had little, if any, opportunity for reflection or feedback. The only feedback available was from any end of course evaluation sheets. Trainers within the combined unit are now able to reflect upon and discuss individual- and group-based evaluations collectively. There is now the capacity to follow up any negative reviews and wherever necessary implement any improvements to the programmes on offer.

A further outcome of this process was the development of the Welsh forum - a community of trainers and others who have a responsibility for violence and aggression management. This

forum has numerous benefits such as opportunities for networking and sharing of good practice. The forum also enables the sharing of specific tactics and strategies for overcoming problems, it also provides for a shared voice with regards to any national initiatives (i.e. the Welsh forum was able to provide a collective response to the Welsh assembly guidelines). The forum is a clear demonstration of collective strength and provides an important sounding board for new ideas as well as formal initiatives.

Another important outcome from the merging of the training functions is one of enabling continued professional development. Trainers are able to attend and participate in formal education because trainer cover can now be managed more flexibly within the team environment. There is also the ability to share experiences and learning from any educational or other events attended.

6.5.4 Project Problems

- There were obvious financial implications of the move which needed to be accounted for.
- There were also problems in terms of where within the Trusts did this type of training function fit in (e.g. Human Resources, Mental Health, Occupational Health, etc.).
- The merge itself was a barrier; there were obvious tensions at first (i.e. one side believing the training they had to offer was superior to the other).
- There were also challenges in terms of how best to present and deliver respective training programmes or how to administer and communicate about particular courses.

6.5.5 Project Solutions

- Management support was available from both sides. Support was very flexible and trainers felt valued.
- The development of a sound business case was also a great facilitator. This obviously showed that the trainers had thought about the move very seriously and covered most eventualities. Importantly, they were able to demonstrate the benefits and how these benefits would be realised. The development of the business case also helped the training team secure extra capital upfront as a result of providing management with realistic forecasts of expenditure and income.
- Having clear communication between the trainers and adapting their own ways of thinking so as to accommodate each others differences also helped the change process.

6.5.6 Lessons Learned

- There are a lot of personal lessons in terms of having to be more flexible (i.e. learning to compromise).
- A key lesson learned was that the change process can be challenging and is often not as easy as it is envisaged at first.
- A great deal of learning occurred individually for each trainer in terms of actually believing their ability to deliver such training effectively.
- A key lesson learned was that it is good to review rules. For example, it was found that out of date policies were actually acting as a barrier to moving forward. Through reviewing what, how and why things were done the Trusts and the training function were able to achieve new things, and operate more efficiently and more effectively.

- There has been a great deal of learning about safety and both Trusts have learned to evolve new ways of thinking about the management of violence and aggression.
- Learning has also occurred with regards to how to evaluate training and how to make use of the evaluations from any reviews of training.

6.6 CASE STUDY FIVE: INTERIM CASE STUDY - TRAINING TRAINERS AN INTEGRATED APPROACH

6.6.1 Background

This Ambulance Service has been providing training in conflict resolution and simple breakaway moves for many years. One key problem for this Trust was that the training programme was licensed by an external provider, resulting in continuous overhead costs associated with new workbooks and training materials, yearly refresher courses for trainers and other costs associated with the administration of this particular programme of training. However, there was a feeling amongst the trainers and management team that, over and above the constraints already outlined, the training programme was not effective in at least two key areas 1) in communicating to staff the proactive work of the organisation and 2) in equipping staff with the necessary skills and capabilities to better understand and manage the challenges they are faced with in terms of violence and aggression in the workplace. As a result, the management team took the decision to review current training practices and examine the need to end the existing contract and re-design a programme of training which delivered against the following design objectives: 1) the programme had to take account of current staff needs and the various situations staff may face; 2) the content of the programme must be integrated with and demonstrate other ongoing initiatives within the organisation to manage and prevent violence and aggression; and 3) the tailored programme of training must support the continuous and more advanced development of both trainers and staff (i.e. one which was competency based) and one without the continuous need for refreshers and the re-licensing of materials. The re-design project is at the needs assessment phase and will be rolled out to staff during April 2006 (a second case study will be written at that stage).

6.6.2 What was done

The management team and trainers conducted an internal review of their own training to assess whether or not the content of the programme was one which they felt delivered against the broader organisational objectives. This comprised conducting internal discussions with the trainers and reviewing end of course assessments. In addition, the existing training programme was subject to an external and independent evaluation. Following the review, the decision was taken to design a tailored programme of training which was both aligned to the objectives as set out by the Security Management Services but was also one where the content of the programme and the models used to help develop an understanding of violence and aggression were underpinned by evidence-based research. This evidence was to comprise both information collected from within the organisational setting as well as information obtained from both national and international research. A process of familiarisation has just been initiated, where the needs (utilising a representative sampling process) of staff, trainers and management will be reviewed utilising both quantitative and qualitative techniques. Other important groups will also be included in the familiarisation process (i.e. Unions, Human Resources, Occupational Health, etc.). Following the familiarisation process a draft programme of training will be developed and the content reviewed with the trainers, management and a representative sample of staff. A train the trainer programme will then be developed to transfer the learning to the trainers. Trainers will be required to develop a series of key competencies identified as being important for the effective delivery of violence management training. Once competent, trainers will be able to deliver the training to all staff. A series of support mechanisms have also been put in place to ensure the continuous development of the trainers.

6.6.3 Outcomes

The expected outcomes of this process will be a detailed review of current needs at various levels (organisational and individual). The new training programme will reflect current thinking in the violence and aggression domain (i.e. help to demonstrate the broader organisational context and not just focus on developing individual skills and abilities) but will also be flexibly designed to allow trainers to have the control to introduce any new or relevant information regarding organisational initiatives into the training programme.

A further outcome of the project will be centred upon providing longer term support of both the trainers and the training function. This support will comprise access to specialist trainers and tailored information for the organisation. Other mechanisms of support are also being considered to support the maintenance and continuous development of the competencies of the trainers.

6.6.4 Project Problems

- There are financial implications of the re-design of the programme, this is the most expensive option of those considered.

6.6.5 Project Solutions

- A comprehensive tendering process was used and the longer term benefits of the programme were reviewed to help justify immediate costs.
- A programme of evaluation is being carried out continuously throughout the re-design of the programme and beyond. The evaluation will assess both content design issues as well as determine issues of transfer and the impact of this programme on various organisational outcomes.
- Various stakeholders are included in project group and the entire process is transparent.

6.6.6 Lessons Learned

- Although these will be documented in the final case study, a key lesson that has been learned is associated with not buying into a programme of instruction which requires annual refreshers of in house trainers and re-licensing to enable continued delivery.

7. PART FOUR: VIOLENCE MANAGEMENT TRAINING REVIEW TOOL

7.1 INTRODUCTION

This tool has been designed to support those responsible for assessing the provision of violence management training. The tool has been designed in a checklist format which can be used as part of a formal/informal interview or discussion with the appropriate representatives from the organisation being inspected. The ultimate aim of this tool is to provide both the reviewer and organisations with support to improve the quality and standards of violence management training.

Although the questions have been worded in a direct/closed fashion (i.e. they will elicit short yes, no answers), users are advised to elaborate on each of the questions by using open ended questions. It is important that a comprehensive understanding is achieved with regards to the systems and processes in place to support the design and delivery of training.

7.2 CHECKLIST TO IDENTIFY AND SUPPORT BEST PRACTICE IN TRAINING

Training Needs Analysis (TNA)			
Is there evidence of a TNA having been done?	**Yes**	**No**	**Partly**
Comments (*note the quality or the detail/depth of the TNA*)?			
Is it clear that the design and delivery of training provided follows from the information obtained during a TNA?	**Yes**	**No**	**Partly**
Comments:			
Are the learning aims and objectives of the training specified? And do they map onto the assessment of need?	**Yes**	**No**	**Partly**
Comments:			
Do the learning objectives for the programme map onto those outlined by relevant national agencies and other bodies (e.g. HSE, SMS, NIMHE, NICE, etc.)?	**Yes**	**No**	**Partly**
Comments:			
Training Content			
Does the content of the training provided cover each of the following:	**Yes**	**No**	**Partly**
1. Understanding the legal context (including, the right to protect yourself and the use of reasonable force).	☐	☐	☐
2. Information and models about why and how violence occurs (including, defining violence).	☐	☐	☐
3. Non-physical management of violence (including, customer care, diffusion/de-escalation, verbal communication skills, non-verbal skills, cultural diversity).	☐	☐	☐
4. Physical intervention/management skills (including, breakaway and control & restraint techniques).	☐	☐	☐
5. Organisational policy, procedures and practices in relation to work-related violence (including, roles and responsibilities of management and staff, reporting etc).	☐	☐	☐
6. Post-incident reactions and support (including, how you might feel after an incident, how to get help internally and externally).	☐	☐	☐
Comments (note the extent of the coverage - in terms of % of time allocated to a particular topic area):			

Is the training curriculum sensitive to those areas which require specialist knowledge, skills and abilities & support (i.e. Learning Disabilities, Mental Health, Elderly, etc.)?	**Yes**	**No**	**Partly**
Comments:			
Training Evaluation			
Has the training been evaluated?	**Yes**	**No**	**Partly**
Comments: If yes, how was the training evaluated? In terms of what outcomes/impact was the effectiveness of training evaluated (for example, was there a simple reliance on end of course (reaction) happy sheets, or were a broader range of outcomes used)? Were assessments made: before training and/or after training? Was a control/comparison group used? How are/were the results of the evaluation used?			

Any other comments:

8. REFERENCES

References have been arranged in the order in which they are referred to in the main report.

1. NAO (2003). *A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression.* Report prepared by the comptroller and auditor general. HC 527. London: National Audit Office.

2. Patrick, J. (1992). *Training: Research and Practice.* Academic Press: London.

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03/06

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